

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 05/23/2024
NAME OF PROVIDER OR SUPPLIER Jewish Home of Central New York		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40803 50561 Based on observation, record review, and interview during the recertification and abbreviated (NY00326481) surveys conducted 5/16/2024-5/23/2024, the facility did not ensure residents were treated with respect and dignity in a manner and environment that promoted maintenance or enhancement of quality of life for 13 of 13 residents (Residents #59 and 12 anonymous residents) reviewed. Specifically, Certified Nurse Aide #36 was observed speaking loudly near the main dining room about Resident #59's urinary drainage device; and multiple staff were observed using their personal communication devices in care areas during working hours. Findings include: The facility Employee Handbook revised 3/1/2015, documented staff were not permitted to use cell phones during work hours and individual earphones were prohibited. The facility policy, Safe, Clean, Homelike Environment revised 3/2024, documented the facility was committed to providing residents with a homelike environment that de-emphasized the institutional character of the setting. The facility policy, Resident Rights revised 6/2000, documented residents had a right to personal privacy and confidentiality of their personal and clinical records. 1) Resident #59 had diagnoses including urinary tract infection and obstructive uropathy (blocked urine flow). The 5/6/2024 Minimum Data Set assessment (a health status screening and assessment tool) documented the resident had severely impaired cognition, had an indwelling catheter (drains urine from the bladder), and was dependent for toileting. The comprehensive care plan initiated 3/20/2024, documented an alteration in elimination related to use of a urinary drainage device. Interventions included the drainage bag was kept covered for dignity. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/20/2024 at 12:24 PM, Certified Nurse Aide #36 brought Resident #59 into the dining room. The resident stated they needed to use the bathroom. Certified Nurse Aide #36 replied loudly to the resident that they had just gotten off the bed pan and had a catheter. There were 4 residents seated nearby. During an interview on 5/21/2024 at 1:38 PM, Registered Nurse Manager #14 stated staff should not talk about resident specific information such as catheters and bed pans when in the dining room as that was not dignified or homelike. An attempt was made on 5/22/2024 at 11:48 AM to conduct a phone interview with Certified Nurse Aide #36, however, the call was not answered. 2) During a resident meeting on 5/16/2024 at 11:11 AM, 12 of 12 anonymous residents reported staff frequently used their cell phones and earbuds in resident care areas. The residents felt staff pretended they could not hear them when they utilized their personal communication devices. During an observation on 5/20/2024 at 9:32 AM, Licensed Practical Nurse #2 was seated with residents at a dining room table during the breakfast meal and was looking at their phone. They did not interact with residents. During an interview on 5/22/2024 at 8:55 AM Licensed Practical Nurse Unit Manager #1 stated cell phones, were not allowed in resident care areas, and there were no exceptions. If staff were on their phones, they were not attending to the needs of the residents. That could result in resident injury, an elopement, or other worse case scenarios. It was also a violation of resident privacy and confidentiality to have personal cell phones in resident care areas. During an observation on 5/21/2024 at 11:01 AM, Certified Nurse Aide #32 was observed to sitting in the television lounge area on the unit using their personal cell phone. They stated they should not be using their personal cell phones in resident care areas. During an interview on 5/21/2024 at 1:38 PM, Registered Nurse Manager #14 stated staff should not be using their personal cell phones in resident care areas. 10NYCRR 415.5(a)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49448 Based on observation, record review, and interview during the recertification and abbreviated (NY00326481) surveys conducted 5/16/2024-5/23/2024, the facility did not ensure the resident's representative was notified when there was a need to alter treatment significantly for 1 of 1 resident (Resident #48) reviewed. Specifically, Resident #48 did not have the capacity to make medical decisions and their health care proxy (person appointed to make healthcare decisions when the individual can no longer do so) was not notified when the resident developed a wound which required treatment. Findings include: The facility policy, Criteria for Assessing Changes in Resident Condition revised 10/11/2023 documented a change in condition was defined as an improvement or decline in physical, mental and/or psychosocial status. Skin breakdown and open areas were included but not limited to examples of a condition change. The licensed nurse notified the provider for further orders, management, or treatment. New orders were initiated by the licensed nurse and a change of condition progress note was documented in the electronic medical record. The resident's family was notified, and family notification was documented in the progress note. Resident #48 had diagnoses including Alzheimer's disease (a progressive disease that alters memory) and urinary incontinence. The 4/28/2024 Minimum Data Set Assessment (a health status screening and assessment tool) documented the resident had severely impaired cognition, was dependent on staff for toileting, hygiene, bed mobility and transfers with a mechanical lift, was at risk for pressure ulcers, and had applications of ointments/ medications other than to feet. The resident's admission Face sheet documented the resident had two family members who were designated as both Health Care Proxies and emergency contacts. The comprehensive care plan initiated 1/6/2021 and reviewed 12/28/2023 documented the resident was at high risk for skin breakdown related to decreased mobility and incontinence. Interventions included incontinence care, certified nurse aide was to report skin conditions daily during care and report any abnormalities to the nurse, maintain turn and position schedule every 2-4 hours, and use skin protectant/ barrier when performing perineal care (washing genital and rectal areas). The 10/18/2023 Assistant Director of Nursing wound team progress note documented the resident had a 3.5 centimeter by 2 centimeter open area to the left buttocks and a 3.5 centimeter by 2 centimeter open area to the right buttocks. The wounds were new and the Assistant Director of Nursing recommended treatment with collagenase (an ointment used to remove dead tissue) and continue current treatment for heels. The 10/18/2023 physician order documented apply collagenase topical ointment 250 unit/ gram once daily to 3.5 centimeter by 2 centimeter open areas to left and right buttocks after cleansing with normal saline and patting dry, then cover with a foam dressing. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the resident's Health Care Proxies/emergency contacts were notified of the new bilateral buttock's wounds and treatment identified by the Assistant Director of Nursing. During an observation on 5/20/2024 at 11:54 AM, Certified Nurse Aides #20 and #21, and Licensed Practical Nurse #18 provided incontinence care to the resident. A reddened area approximately the size of a ping pong ball was noted to the middle right buttocks. Licensed Practical Nurse #18 said this area was reported to them this morning by an unidentified certified nurse aide and they had not seen it yet. Licensed Practical Nurse #18 left the room and returned with the Assistant Director of Nursing. The Assistant Director of Nursing stated the area to the buttocks was new and this was moisture associated skin damage. Licensed Practical Nurse #18 applied the ordered zinc ointment per the Assistant Director of Nursing's direction. There was no documented evidence through 5/21/2024 the resident's Health Care Proxies/emergency contacts were notified of the new buttocks wound identified on 5/20/2024 by the Assistant Director of Nursing. During a telephone interview on 5/22/2024 at 8:48 AM the resident's designated Health Care Proxy/emergency contact stated in 10/2023, they observed wounds on the resident's buttocks during incontinence care that they were never notified of and wondered how long they had been there. They were not aware of any current wounds to the buttocks. They visited often and stated they did not get updated on any wounds but asked to see the chronic foot wounds when they visited. They thought they should be updated on new wounds. They attended care plan meetings and was only updated on the resident's wounds during the meetings when they asked about them. During an interview on 5/22/2024 at 10:07 AM Licensed Practical Nurse Unit Manager #17 stated families were notified of any change in condition. Family should also be notified of new wounds and changing wounds. It was important for quality of life and permission for treatment. Resident #48 was not cognitively intact, and their family should be notified. The resident's family member liked to be involved and attended all outside wound appointments in the past. If the resident's family was notified for any reason, it should be documented in a progress note. During an interview on 5/22/2024 at 10:42 AM the Assistant Director of Nursing stated family representatives were updated on change of condition that included incidents, new and changing wounds, as well as medication changes and care plan changes. They did not notify Resident #48's representative of the buttocks wounds they identified on 10/18/2023 or the new buttock wound identified on 5/20/2024 and they should have. 10NYCRR 415.3(e)(2)(ii)(b,c)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27522 Based on record review, observation, and interview during the recertification survey and abbreviated (NY00311928 and NY00326481) surveys conducted 5/16/2024-5/23/2024, the facility did not ensure a safe, clean, comfortable, and homelike environment for 3 of 3 resident floors (Terrace floor unit, first floor unit, and second floor unit) reviewed. Specifically, the Terrace floor unit had unclean resident wheelchairs, damaged and sticky flooring, and damaged countertops; the first floor unit had sticky floors in the dining room; and the second floor unit had a resident room with a damaged commode, a spa room with a water damaged cabinet, cigarettes and loose tobacco were kept in the second floor unit kitchenette, and the noise level in the dining room was loud during meal service. Additionally, the Terrace floor unit, first floor unit, and second floor unit had spa access doors that self-locked from the inside when opened too hard. Findings include: The facility policy, Safe, Clean, Homelike Environment revised 3/2024, documented all staff were responsible for the creation and maintenance of a clean, safe, homelike environment and a pleasant dining experience that promoted social interaction. 1) Unclean Resident Wheelchairs During observations on 5/16/2024 at 10:42 AM and 5/17/2024 at 1:03 PM, Resident #26 was in the Terrace unit lounge area seated in their positioning recliner chair. The chair had dried food debris on the footrest and the side of the chair. During observations on 5/16/2024 at 10:37 AM and 2:23 PM, 5/17/2024 at 8:53 AM and 1:13 PM, Resident #41 was observed seated in their wheelchair on the Terrace Unit. Their wheelchair was unclean with dried food debris on the frame. During an interview on 5/22/2024 at 10:05 AM, Licensed Practical Nurse Unit Manager #6 stated certified nurse aides on the 11:00 PM-7:00 AM shift were responsible to ensure resident wheelchairs were cleaned. If staff noticed the chairs were unclean on the resident's shower day, they should be cleaned. It was easier to clean the chairs on the night shifts as the residents were typically in bed. Unclean chairs were undignified and were a potential infection control issue. During an interview on 5/22/2024 at 10:27 AM, certified nurse aide #7 stated they were unsure if Resident #26's and Resident #41's chairs were unclean or stained because they appeared to be old. The 11:00 PM-7:00 AM shift was responsible to ensure the resident's chairs were clean. Anyone could clean a resident's chair if they noticed it was unclean. Unclean chairs were undignified and a possible infection control issue. During an interview on 5/22/2024 at 10:49 AM, the Director of Environmental Services stated nursing was responsible to ensure wheelchairs were cleaned. Wheelchairs were cleaned mostly during the third shift or during resident showers. They stated they did not notice any unclean wheelchairs during a recent walk through of the facility. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Loud Environment During an observation on 5/16/2024 at 2:07 PM, an unidentified dietary aide cleared trays and dishware from the tables in the second floor unit dining room. They picked up the dishware, scraped it off, and placed it in bins on a wheeled cart. This scraping and placement of the dishes in the bins caused a very loud clatter, and they continued to do this from table to table. There were seven residents in the dining room eating. At 2:13 PM, three residents remained in the dining room eating. The unidentified dietary aide began removing dishes from one of the tables a resident was eating at, and loudly scraped the food off the plates. During an observation on 5/17/2024 at 10:18 AM, the same unidentified dietary aide from the 5/16/2024 observation was in the second floor unit dining room. They moved from table to table and cleared dishes. Residents were still in the dining room eating at tables that were being cleared by the dietary aide. They scraped and then placed breakfast dishes in bins in a manner that caused loud clatter. They attempted to remove a tray of food that was in front of Resident #57 without asking if the resident was done eating. The resident leaned forward and said, no, no, no. The unidentified dietary aide then slid the tray back over to the resident. During an observation on 5/17/2024 at 1:21 PM, the second floor dining room had meal cart #2 plugged into the wall in the dining area between tables of the residents. The cart was very loud, and it was difficult to hear the residents or staff talking. At 1:23 PM, Certified Nurse Aide #12 stated this is very loud and closed the cart doors and said it was much quieter. At 1:25 PM, another unidentified staff member stated, that cart is too loud and unplugged the tray cart. During an observation and interview on 5/20/2024 at 8:55 AM, a loud beeping was heard coming from room [ROOM NUMBER]. Resident #44's tube feeding machine had completed the feeding and was beeping. The beeping continued until 9:41 AM (46 minutes later). Licensed Practical Nurse Unit Manager #1 entered the room and shut the tube feeding machine off. They stated the tube feeding ran for 12 hours and was started at 8:00 PM. They stated they should have shut off the tube feeding pump when it first started beeping but they were in the dining room assisting residents and could not be in two places at once. During an observation on 5/20/2024 at 10:22 AM, Licensed Practical Nurse #8 was assisting Resident #69 with their breakfast. An unidentified dietary aide was loudly dropping all the dishes from the table into the cart. They wiped the table down while the resident was still at the table being assisted with breakfast. During an interview on 5/22/2024 at 10:03 AM, Dietary Aide #4 stated they always tried to give the residents enough time to eat before the dining room was cleared and did not want to be in the way while the residents were eating. They stated the goal was to have the breakfast trays delivered to the unit by 9:00 AM, and the dining room was cleared no earlier than 10:00 AM, but sometimes things ran late. Dietary Aide #4 stated they sometimes had to clear trays while residents were still in the dining room because if they did not, it caused the next meal to be late. They stated if they had to clear while residents were still in the dining room, they started clearing on the side of the dining room that was served first, as those residents were typically done eating and already moved out of the dining room. They stated they would not clear from a table that a resident was still eating at as it would not be a nice or dignified experience for that resident. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2024 at 9:49 AM, the Food Service Director stated the resident food hot boxes should be kept in the unit side hallways during use and should not be placed in the resident dining rooms. Once all residents were finished eating at a table staff cleared that table, even if residents at a table next to were still eating. They stated this had been the table clearing process for the last [AGE] years, and the Rabbi preferred a two hour window before the next meal due to kosher guidelines. The Food Service Director stated milk products and meat products could not be in the dining room at the same time, and that was why a table would be cleared immediately after all residents were done eating. During an interview on 5/22/2024 at 12:20 PM, the Administrator stated the warming units made some noise and they should be plugged in the unit 2 hall and not plugged in the dining room. 3) Unit Spa Self-Locking Doors During an observation on 5/20/2024 at 11:34 AM, Resident #56 was taken into the second floor shower room. At 12:00 PM, Certified Nurse Aide #27 exited the shower room alone. At 12:12 PM Certified Nurse Aide #27 returned to the shower room, but the door was locked, and the resident was inside. They went to get the nurse and returned to the shower room door and waited for the nurse. The nurse arrived moments later, and the key did not work. The nurse retrieved a different key and was able to unlock the door. During an observation on 5/20/2024 at 1:10 PM, the second floor spa room door locked from the inside when pushed open. If the door was pushed hard it opened into the room, and the push button door lock on doorknob inside the room was pressed, locking the door from the inside. On 5/20/2024, between 3:30 PM and 3:38 PM, the following was observed: - the first floor unit side spa door locked from the inside when pushed open. If the door was pushed hard it would open into the room, and the push button door lock on doorknob inside the room was pressed, locking the door from the inside. - the Terrace unit Lane side spa locked from the inside when pushed open. If the door was pushed hard it would open into the room, and the push button door lock on doorknob inside the room was pressed, locking the door from the inside. During an interview on 5/22/2024 at 10:54 AM, the Director of Environmental Services stated they were not aware the doors for the second floor spa, the first floor spa, and the Terrace unit lane side spa self-locked from the inside when the lock/unlock button hit the wall. They stated they had not heard of any residents being locked inside a facility spa room or staff needing to get a key to unlock the door. Those doors were original to the building. They stated maintenance of a safe environment for residents was important. 4) Unclean Floors/Ceiling Tiles/Resident care areas During observations on 5/16/2024 at 10:28 AM and 5/17/2024 at 8:36 AM, the first floor unit dining room floor was sticky. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations on 5/16/2024 at 12:16 PM, 5/17/2024 at 8:36 AM, and 5/20/2024 at 9:31 AM, the Terrace unit dining room floor was sticky. There were several stained ceiling tiles throughout the dining room. On 5/16/2024, between 11:50 AM and 1:10 PM, the following was observed on the second floor: - resident room [ROOM NUMBER]'s bathroom had a commode with sections that were oxidized with bubbled paint. - the second floor unit lane side spa room cabinet had a section that was water damaged. - the second floor unit kitchenette had a staff food bag in the non-kosher refrigerator that contained loose tobacco and cigarettes. On 5/16/2024, between 12:41 PM and 1:00 PM, the following was observed on the Terrace floor unit: - the Terrace ridge unit side spa room had a section of floor with a missing tile, and a countertop that was chipped with exposed plywood. - resident room T17's floor was scraped with black marks. - the Terrace unit ridge side entrance to the dining room had a cabinet/sink with cracked drawers. During an interview on 5/17/2024 at 2:40 PM, the Director of Environmental Services stated all staff food bags should go in the staff break room. The second floor non-kosher refrigerator had a sign on it which read for residents only. They stated the second floor kitchenette was not where staff personal bags were stored. There should be no smoking material in the kitchenettes since family members and residents had access to these rooms. During an interview on 5/21/2024 at 1:24 PM, the Director of Environmental Services stated the dining room floors were mopped after every meal, a neutral floor cleaner was utilized, and they had never been told about sticky floors. The same floor cleaning chemical had been used for a few years. A daily task of the housekeeping staff was to clean the floors in the facility. They stated the commode in the bathroom of resident room [ROOM NUMBER] was in disrepair, and it did not look homelike and should have been replaced. Staff should have identified the commode and reported it to the maintenance department to be replaced. They were not aware of the cabinet with the damaged water section in the second floor lane side spa, or of the missing floor tile and the damaged countertop in the terrace ridge spa. These findings should have been identified by staff on the floor and reported to the maintenance department. The floor in resident room T17 floor was at the threshold to be stripped and waxed. They would usually complete this task when rooms were empty, but if a resident was living in the room they would be removed for a few hours and the room floor would be stripped and waxed. They were not aware the surface of the doors to the cabinet in the Terrace dining room were in disrepair and were not homelike. They would periodically tour the facility including sampling resident rooms and common areas. This was not documented. The Director of Environmental Services stated it was important a safe and clean environment for residents and staff was maintained. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40803 Based on record review and interview during the recertification and abbreviated (NY00326481 and NY00334060) surveys conducted 5/16/2023-5/23/2024, the facility did not ensure all alleged violations involving abuse, neglect, or mistreatment were thoroughly investigated for 2 of 3 residents (Resident #48 and 119) reviewed. Specifically, Resident #48 had an unwitnessed fall that was not investigated; and Resident #119 had injuries of unknown origin that were not thoroughly investigated. Findings included: The facility policy, Falls Management and Prevention revised 10/11/2023, documented after a fall, the licensed nurse initiated an incident report and staff provided written statements. Written statements included time and location the resident was last seen, behavior pattern of the resident, what the resident was doing at the time of the incident if known, and any change in activity of daily living status. The supervisor on duty contacted the provider and the resident's family and documented in the medical record and included the time and the person spoken with. A resident was evaluated 72 hours post fall and included vital signs every shift and neurological check (evaluates neurological function) protocol. The facility policy, Incident Occurrence and Reporting created 10/11/2023, documented the facility was responsible to investigate all incidents and maintain records of each investigation. The facility staff was responsible for investigating and reporting alleged violations of mistreatment, neglect, and abuse, including injuries of unknown source to the New York State Department of Health. The unit licensed practical nurse or Nursing Supervisor would initiate an incident report for the following occurrences including falls, bruises, and injuries of unknown origin. The incident reports would be filled out correctly, complete, and document the time and location of incident; the location and description of injury; vital signs; the cause of the incident, if known; any statements made by the resident and any witness; and the time and date family and medical were notified. The unit nurse or designee would complete the Accident and Injury report, copy any pertinent parts of the chart and staff statements. These documents would be delivered to the Director of Nursing or designee for review. The Director of Nursing and/or designee would review the incident and follow up for completion and appropriateness. Obtain and track all incident reports within a reasonable time frame to ensure prompt review. Conduct follow up investigations to establish root cause, make determinations of identifiable or unidentifiable reasonable cause. The interdisciplinary team would review all adverse incidents at team meeting during morning report. The Director of Nursing/Administrator would examine incident reports and investigations for completeness and accuracy and file reports according to the facility, state, and federal regulations. 1) Resident #119 was admitted with diagnoses including Parkinson's disease (a progressive neurological disorder), neurocognitive disorder with Lewy bodies (a type of dementia), and repeated falls. The 1/13/2024 Minimum Data Set Assessment (a resident assessment tool) documented the resident had severely impaired cognition, rejected care 1-3 days, had functional limitation to one arm, required substantial/maximal assistance with upper and lower body dressing, supervision or touching assistance with sit to stand, chair/bed-to-chair transfers, and walking 10-150 feet. The resident had 2 or more falls since admission/entry or reentry or prior assessment with no injury or injury (except major). (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/6/2023 comprehensive care plan documented the resident had a cognitive deficit related to Lewy Body dementia. Interventions included independent with bed mobility, ambulation, and transfers; provide assistance with bed mobility, transfer with staff assistance, ambulates self at times/ staff assist of 1 or 2 for balance. The resident was at risk for falls. Interventions included investigate cause of fall immediately, evaluate pattern of falls if the resident fell more than once, anticipate resident needs, keep family informed of falls, use appropriate assistive devices and level of assistance as recommended, and ensure proper footwear. Nursing progress documented: - on 5/1/2024 at 6:11 AM Registered Nurse #30 documented at 3:30 PM a certified nurse aide reported the resident had been walking around the unit all night. When the certified nurse aide finished their care with another resident, they found Resident #119 lying on their right side in the common area. They alerted the nurse and the resident got up and was walking around again. No injuries were observed, and the resident continued to walk the unit with staff supervision. - on 5/2/2024 at 4:04 PM, Registered Nurse Unit Manager #14 documented a follow up regarding the 5/1/2024 fall. The resident reopened a previous skin tear to the lateral left elbow. Nurse Practitioner # 35 was made aware that the resident was walking bent over. Vital signs were within normal limits and their abdomen was soft and non-tender. - on 5/6/2024 at 2:15 PM, Registered Nurse Unit Manager #14 documented the resident had an order for bladder, kidneys, and ureter x-rays, and an ultrasound (an imaging test) on the left and right side of the abdomen. - on 5/7/2024 at 8:17 PM, Licensed Practical Nurse Unit Manager #17 documented they were called to the unit as the resident fell in their room. The certified nurse aide (unidentified) was filling out paperwork and when they looked back the resident was on the floor. The on-call medical provider was notified and ordered an x-ray of the cervical spine (neck area). - on 5/8/2024 at 4:28 PM, Registered Nurse Unit Manager #14 documented the resident had a fall witnessed by ultrasound technician #43 (during a portable ultrasound at 6:00 AM). Their range of motion was at their baseline and neurological checks were intact. The resident reopened a left elbow skin tear. - on 5/8/2024 at 1:22 PM, Nurse Practitioner #35 documented they rounded with the resident who sustained a fall the previous night. The cervical spine x-ray results were within normal limits. The resident was doing well without signs of distress. The resident had been seen for abdominal pain. The ultrasound showed possible gallstones and medical was awaiting radiology's official results. At 4:03 PM, the radiology report was positive for gallstones and the resident was sent to the hospital. The 5/8/2024 hospital computed tomography (CT, imaging test) report documented there was an acute (recent) appearing mildly displaced left eighth posterior (back) rib fracture. There were more chronic appearing fractures of the right ribs 8-11. A 5/9/2024 at 1:22 AM Registered Nurse #30 progress note documented the resident returned from the hospital at 12:30 AM. Their computerized tomography scan revealed a broken left 8th rib and gallstones with no signs of infection. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 5/10/2024 at 2:30 PM, Nurse Practitioner #35 progress note documented the resident was seen for a follow up visit following a hospital visit for abdominal pain. It was determined the resident had a fractured rib and gallstones. There was no documented evidence that the facility investigated to determine how and when the resident sustained a fractured rib. During a telephone interview on 5/21/2024 at 4:32 PM Nurse Practitioner #35 stated they reviewed accident and incident reports with the interdisciplinary team during morning report. Resident #119 was exhibiting signs of abdominal pain and an ultrasound was ordered. The resident was assessed for abdominal pain and showed no signs of discomfort. They were sent to the hospital for gallstones and a scan at the hospital revealed gallstones and a fractured rib. It was a closed fracture, and it was hard to determine when it occurred. The resident did have frequent falls and they recently had a cervical spine x-ray that did not show the fractured rib so it must have occurred after that x-ray. During an interview on 5/21/2024 at 4:43 PM the Administrator stated accident and incident reports were started after an incident occurred. The report was reviewed with the interdisciplinary team during morning report. Resident #119 had a witnessed fall in their room after an ultrasound. They were sent to the hospital for abdominal pain and while there, their scan revealed they had a fractured rib. The team determined the fractured rib was a result of the 5/8/2024 witnessed fall. During an interview on 5/21/24 at 1:30 PM Registered Nurse Unit Manager #14 stated all accident and incident reports were reviewed by the interdisciplinary team in morning report. They were started once the incident occurred. Witnessed statements were obtained going back 3 shifts if an injury of unknown origin occurred. Resident #119 had a witnessed fall on 5/8/2024 and was sent out to the hospital for abdominal pain. During their hospital stay a fractured rib was identified. They had completed the accident and incident report for the witnessed fall prior to the resident being sent to the hospital and were not sure if an accident and incident report should have been started once the rib fracture was identified upon their return. The rib fracture was considered a new diagnosis at that time. 2) Resident #48 was admitted to the facility with diagnoses including Alzheimer's disease (a type of dementia) and repeated falls. The 8/30/2023 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent for bed mobility, transfers, and locomotion with a wheelchair, and had no falls since admission or the prior assessment. The comprehensive care plan initiated 1/6/2021 documented the resident had a potential for falls. Interventions included, tender mattress on the floor next to the bed as an extension of their bed, call bell was in reach and answered promptly, and bed was kept in the lowest position. The care plan documented actual falls on 1/13/2021 (updated 1/14/2021) and 3/1/2021 (updated 3/2/2021). There were no updated interventions or other documentation of actual falls after 3/2/2021. A 10/16/2023 at 10:22 PM Licensed Practical Nurse #41 progress note documented Resident #48 was found at shift change face down at their bedside. They had a knot on their forehead and bruising to their left wrist. The on-call registered nurse, nurse practitioner, and daughter were all made aware of the fall. The resident denied any pain and neurological checks were initiated per the nurse practitioner. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the resident was assessed by a registered nurse after the fall. A 10/17/2023 at 11:11 AM Licensed Practical Nurse Unit Manager #17 progress note documented a referral to occupational therapy due to fall and the resident needed a new wheelchair. A 10/18/2023 at 1:51 PM Licensed Practical Nurse Unit Manager #17 progress note documented the resident was day 2 post fall and doing great, range of motion was within normal limits, and the resident had no complaints of pain. A physical therapy referral was placed for falls. On 5/20/2024 the Accident and Incident report from Resident #48's fall on 10/16/2023 was requested from the Administrator. There was no corresponding report received for the incident. There was no documented evidence that the facility investigated regarding the 10/16/2023 unwitnessed fall and noted injuries to rule out abuse or neglect. During an interview on 5/21/2024 at 1:26 PM the Administrator stated an accident and incident report could not be located for Resident #48's fall on 10/16/2023. They stated there was staff turnover and the previous Director of Nursing was very secretive. During an interview on 5/21/2024 at 1:27 PM Certified Nurse Aide #22 stated falls were reported to the licensed practical nurse, and they stayed with the resident until an evaluation was completed by the registered nurse. Vital signs were obtained by the licensed practical nurse after a fall and then statements were provided by staff. During an interview on 5/22/2024 at 10:07 AM Licensed Practical Nurse Unit Manager #17 stated they were notified after a fall. Staff stayed with the resident and a registered nurse completed an assessment. If the registered nurse was not on the premises, a virtual phone assessment was completed. The physician and the family were then notified, and physician orders were followed. Licensed Practical Nurse #41 no longer worked at the facility. They were not sure if Resident #48 had a fall in October 2023. After a fall, all staff provided statements and it was discussed in daily report, care plans were reviewed and updated as needed. An accident/ incident report was completed. It was important for follow up care and for 2-3 days after a fall and ensure neurological checks and vital signs were completed. Every fall should have an accident and incident report for clarification of what happened, so an underlying cause could be identified, infections could be treated, or equipment could be modified. During an interview on 5/22/2024 at 10:42 AM the Assistant Director of Nursing stated if a certified nurse aide found a resident on the floor, a staff member stayed with the resident and either they or another registered nurse was contacted to do a physical assessment. The provider and the family were then notified. Unwitnessed falls required neurological checks for 72 hours and an accident/ incident report was completed. If it was a fall during the day, the accident/ incident report was initiated by Licensed Practical Nurse Unit Manager #17. If a fall occurred during off hours, the nursing supervisor was notified would start the incident report and gather statements from staff. The next business day falls were reviewed during morning report with the clinical team, the Director of Nursing, and the Administrator. All falls required an accident and incident report and were important for tracking purposes and the investigation led to interventions that needed to be added. They could not recall if Resident #48 had a fall in October 2023. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.4(b) 49448		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50561 Based on observation, record review, and interviews during the recertification survey conducted 5/16/2024-5/23/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for 1 of 1 of resident (Resident #52) reviewed. Specifically, Resident #52 did not have resident-specific interventions for the use of an indwelling urinary catheter (a tube placed in the bladder to drain urine). Findings include: The facility policy, Foley Catheter Use dated 12/2017, documented specific guidelines for the use of foley catheters would be provided on all patients within the facility and a comprehensive resident centered care plan would be developed. Resident #52 had diagnoses including cerebral vascular accident with right side hemiplegia (stroke with right side paralysis) and an unspecified open wound to the buttock. The 3/30/2024 Minimum Data Set assessment (resident assessment tool) documented the resident had severe cognitive impairment, had an indwelling urinary catheter, and had 3 unstageable (full thickness tissue loss with a wound base is covered with dead tissue) pressure injuries. Physician orders documented: - 2/21/2024 insert a urinary catheter to prevent further maceration (softening of skin due to moisture) to buttocks and to facilitate healing. - 2/24/2024 change catheter bag every 2 weeks; may change urinary catheter if plugged, leaking, or out; may irrigate urinary catheter with 50 milliliters of normal saline every shift and as needed if plugged or leaking; record output each shift. A 2/23/2024 at 11:41 AM Licensed Practical Nurse Unit Manager #1 progress note documented a physician order to insert a urinary catheter to prevent further skin maceration. A catheter was inserted that morning and was draining yellow urine. The comprehensive care plan effective 12/1/2023 and reviewed on 2/29/2024, documented the resident had urinary incontinence. The comprehensive care plan did not include documentation of the use of a urinary catheter. The comprehensive care plan effective 4/23/2024 documented the resident had skin breakdown located on the sacrum (upper buttocks) and the right gluteal region (buttocks). Interventions did not include the use of a urinary catheter. The 5/20/2024 resident care instructions (Kardex) did not document the use or care of a urinary catheter. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/16/2024 at 10:16 AM, the resident urinary collection bag was in a dignity bag. There was yellow urine with white sediment in the connection tubing. During an observation on 5/21/2024 at 10:30 AM, the resident's urinary collection bag was in a dignity bag. There was yellow urine with white sediment in the connection tubing. During an interview on 5/21/2024 at 11:38 AM Licensed Practical Nurse Manager #1 stated physicians wrote the orders for the insertion of a catheter. The order would come up as a task for the nurses to complete. That task should be signed for and documented by whomever placed the catheter or performed any of the related ordered interventions. They stated Resident #52 had a catheter because of wounds on their bottom. There was an order for routine catheter flushes to maintain patency impaired patency may have been a factor in the prior infection. They expected staff to report any changes in urine output, urine consistency, or urine characteristics and that the catheter was being changed as ordered. These should be included in the care plan. If they were not in the care plan or not followed up on, it could increase the risk for an infection. 10NYCRR 415.11(c)(1)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 48675 49448 Based on observation, record review, and interview during the recertification and abbreviated (NY00311928 and NY00320383) surveys conducted 5/16/2024-5/23/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 3 of 8 residents (Residents #31, #95 #103) reviewed. Specifically, Resident #31 was not assisted with showering, washing their hair, and removing facial hair; Resident #95 was not assisted with nail care; and Resident #103 was not assisted with toileting. Findings include: The facility policy, Physical Care/ADLs (activities of daily living) dated 11/2014, documented each morning and evening, the resident had attention to elimination, partial bathing, mouth care, hair combing, and dressing in clean clothing. Each resident had a minimum of one shower or tub bath per week and one bed bath per week. Nursing provided some choices in the bathing schedule. Each resident had an individualized plan for their hair care based on their wishes, and fingernails and toenails were kept clean and at the appropriate length. Male residents were shaved as often as necessary to keep them comfortable and neat, and females were free from facial hair unless they choose not to have the hair removed. The facility policy, Toileting Residents dated 8/2015 documented the registered nurse indicated time frames the resident should be toileted on the resident personal care sheet, and the time selected reflected the individual needs of the resident on a 2-4 hour basis and as needed during the night. This was recorded under the toileting section on the personal care record. After toileting, the certified nurse aide initialed in the correct space and indicated the time the resident was toileted. The certified nurse aide assignment sheet, resident care plan, and person care record reflected the resident's toileting approaches. 1) Resident #31 had diagnoses including dementia and cellulitis (skin infection) of the buttock. The 3/28/2024 Minimum Data Set assessment (health assessment tool) documented the resident had severe cognitive impairment, required substantial to maximal assistance with showering, and was dependent for personal hygiene. The comprehensive care plan last reviewed 12/27/2023 documented the resident required assistance with activities of daily living. Goals included the resident would be neat, clean, and well-groomed daily. Interventions included assistance of one staff for personal hygiene and toileting tasks, provide grooming needs, shower weekly per schedule, and shampoo hair with showers. The care instructions (Kardex) last updated on 3/28/2024 documented the resident was dependent on staff for care and would have their shower on Mondays during the day shift. The resident was observed: (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 5/16/2024 at 10:38 AM, seated outside of their room in a reclining position chair. Their shoulder length hair appeared wet and greasy on the top and the back of their head. There were white flakes on their scalp. The resident had multiple 1/2 inch white gray hairs on their chin. The resident asked how many whiskers they had while trying to pull them out and stated, I have cat whiskers. - on 5/17/2024 at 9:36 AM, sitting in their reclining position chair. Their hair was greasy with white flakes on the scalp. The resident had multiple 1/2 inch white gray hairs on their chin. - on 5/20/2024 at 9:09 AM, lying in bed, dressed in grey pants and a long blue sleeve floral print shirt. Their hair appeared wet and greasy. The resident had multiple 1/2 inch white gray hairs on their chin. The certified nurse aide documentation for Resident #31 from 5/1/2024-5/20/2024 included: - on Monday 5/6/2024 there was no documentation care was provided. - on Monday 5/13/2024 a shower was documented as self-care. - on Monday 5/20/2024 there was no documentation a shower was provided. - on Tuesday 5/21/2024 and there was no care documented. During an interview on 5/21/2024 at 1:54 PM, Registered Nurse Unit Manager #14 stated staff reviewed the resident care plan for assistance level, shower days, and specifics for the resident. They had a shower schedule which matched the care plan and the tasks sheets. All resident care should be documented in the electronic medical record. If the care section was left blank, they could not determine that care was completed. If a resident refused care the aide should let the nurse know and then reapproach the resident. If the resident had refused showers they should have been notified. Personal hygiene included shaving of both men and women if they wished and should be done daily. Resident #31 had a history of refusals, but they were not made aware of any shower refusals. It was not dignified for women to have facial hair or greasy hair. They did notice the facial hair on Resident #31's chin. Every resident should be provided a shower and if they did not want one a note should have been written in the record why they did not receive a shower. If a shower was not provided a bath should be given instead so the resident felt clean. During an interview on 5/22/2024 at 9:50 AM, Licensed Practical Nurse Unit Manager #6 stated Resident #31 should have received daily care and that should have included removal of facial hair, washing their hair, and receiving their weekly showers. If a resident had dirty greasy hair, it was dignity issue and good hygiene was important for resident care. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2024 at 10:12 AM, Certified Nurse Aide #7 stated they reviewed the care plan to find specifics for the resident's care including personal care needs and shower days. Personal hygiene consisted of oral care, facial care, cleaning, shaving men and women, and nail care. They stated they were responsible for Resident #31's care last week and the resident did not refuse care. They did not always have time to document the care they provided. They stated they did not give the resident a shower, wash the resident's hair, or remove the facial hair. They were aware of the resident's chin hair and should have shaved or trimmed it and completed the resident's shower. They stated the resident's hair was greasy and they should have washed the resident's hair even if it was not their shower day. They reviewed the documented care and stated it appeared the resident only received one shower in a month. 2) Resident #95 had diagnoses including Alzheimer's disease (a type of dementia) and hypertension (high blood pressure). The 3/2/2024 Minimum Data Set assessment (a health assessment tool) documented the resident had severe cognitive impairment and required substantial to maximal assistance for personal hygiene. The 3/14/24 care instructions documented the resident required maximal assistance with bathing which included nail care, and their shower was scheduled on Thursday during the day shift. The certified nurse aide documentation documented the resident received a bath during the day shift on 5/16/24 but did not receive personal hygiene care on 5/2/24, 5/4/24, 5/7/24, 5/8/204, 5/9/2024, 5/10/24, and 5/12/24. During an observation on 5/16/2024 at 10:18 AM, the resident's fingernails were approximately 1/4 inch long and jagged, with a dark brown substance under all 5 nails on the right hand and under the left thumb nail. During an observation on 5/20/2024 at 10:41 AM, the resident's fingernails were long and jagged with dark brown debris under all 10 fingernails. During an interview on 5/21/2024 t 9:20 AM, Licensed Practical Nurse Unit Manager # 26 stated the resident's shower was scheduled for Thursdays during the day shift. During an observation on 5/21/2024 at 11:34 AM, the resident's fingernails were long with dark brown debris under all 10 fingernails. During an interview on 5/21/2024 at 1:54 PM, Registered Nurse Unit Manager #14 stated staff reviewed the resident care plan for assistance level, shower days, and specifics for the resident. All resident care should be documented in the electronic medical record. If the care section was left blank, they could not determine that care was completed. Personal hygiene included ensuring nails were clean, trimmed and filed. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2024 at 9:50 AM, Licensed Practical Nurse Unit Manager #6 stated staff should review the care task sheet (care instructions) that was generated from the care plan for the resident's activity daily living care. This included shower day and any specific cares for the resident. Personal hygiene consisted of nail care (clean and trimmed). Resident #95 was not diabetic, and the aides should have completed the residents nail care. They stated it was important to keep nails clean and short as it was a dignity issue and infection control issue as bacteria could pool under the nail beds. During an interview on 5/22/2024 at 10:08 AM, Certified Nurse Aide #7 stated the resident did not refuse care and they had not noticed the resident's nails were dirty or they would have cleaned them. They stated the resident's nails should be clean and kept short to prevent them from scratching themselves and to keep bacteria from underneath the nails. They stated the certified nurse aide documentation indicated the resident received one shower in May. They stated based on the lack of documentation it appeared the resident did not receive showers on their shower days. It was important to document care otherwise it looked like the care was not complete. 3) Resident #103 had diagnoses including dementia, urge incontinence (an urgent and uncontrollable need to urinate), and a history of urinary tract infections. The 2/18/2024 Minimum Data Set assessment (a health assessment tool) documented the resident had severely impaired cognition, did not reject care, was dependent for toileting, was frequently incontinent of urine and always incontinent of bowel. The comprehensive care plan reviewed 11/16/2023 documented the resident had an activity of daily living deficit. Interventions included assistance with toileting, brief/pad changes, and toilet before all meals. The resident was incontinent of bladder and would be maintained on a toileting program that promoted dignity and prevented skin breakdown. Interventions included redness and skin breakdown were monitored during toileting/ brief changed every 2-4 hours and as needed, and maintain toileting schedule every 2-4 hours and as needed. The May 2024 certified nurse aide documentation for Resident #103 did not document toileting was completed: - on 5/16/2024-5/17/2024 on the day, evening, or night shifts. - on 5/18/2024 and 5/19/2024 on the evening shift. - on 5/20/2024 on the day, evening, or night shifts. The following continuous observation of Resident #103 was made on 5/21/2024 from 8:49 AM to 2:22 PM: - at 8:49 AM sitting in their reclining position chair being assisted with breakfast. - at 9:39 AM, being wheeled to the common pod area in reclining position chair. - at 11:37 AM, being wheeled into the dining room. - at 12:33 PM being wheeled to the common area. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- at 1:36 PM being wheeled to the music activity by the nursing station. - at 2:22 PM at the music activity sitting in their reclining position chair. Resident #103 was not provided with toileting/ incontinence care during this time. During an interview on 5/21/2024 at 1:47 PM Certified Nurse Aide #22 stated all residents were toileted every 2-4 hours whether they were continent or incontinent. Toileting was important for urinary tract prevention, and it prevented skin breakdown. Resident #103 was incontinent. They thought they toileted the resident around 9:00 AM but had not toileted them since 9:00 AM because they were busy. They stated the resident should be toileted frequently because they could not speak for themselves. During an interview on 5/22/2024 at 9:46 AM Licensed Practical Nurse #19 stated residents were toileted every 2-4 hours and as needed. Incontinence care was important for dignity, illness and infection prevention and good hygiene. It was not appropriate for anyone to be in the same incontinence brief for 6-7 hours as it promoted skin breakdown. Resident #103 sometimes verbalized they needed to use the bathroom but should still be toileted regularly. During an interview on 5/22/2024 at 10:07 AM Licensed Practical Nurse Unit Manager #17 stated all residents were toileted or provided with incontinence care every 2-4 hours for urinary tract infection prevention and wound prevention. It was not appropriate for any resident to be in the same incontinence brief for 6-7 hours and Resident #103 should have been offered to be toileted. 10NYCRR 415.12(a)(3)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 40803 Based on observation, record review, and interviews during the recertification survey conducted 5/16/2024-5/23/2024, the facility did not ensure ongoing provision of programs to support each resident in their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 4 of 4 residents (Residents #26, #41, #109 and #119) reviewed. Specifically, Residents #26, #41, #109 and #119 were not offered meaningful activities of their choosing as care planned. Findings include: The facility policy, Activity revised 3/2024, documented the activity department would provide an organized and ongoing program for the residents. The program would meet the interests, physical, mental, and psychosocial well-being for reach resident. The activity programs would be developed in accordance to meet resident specific and individual needs/interests. All residents would be encouraged, reminded, and assisted to be involved no matter their level of ability. Each resident's monthly participation would be tracked by the activity aides. The facility policy Sensory Stimulation dated 4/2024 documented the activity department would provide group or individual sensory stimulation for those residents who may exhibit cognitive deficits, confusion, or disorientation. Sensory stimulation was the activation of one or more of the senses such as taste, sight, hearing, smell, and touch. Sensory stimulation was a key component for improving the quality of life for those living with dementia. Types of visits/ programs may include, but were not limited to music appreciation group, programs, or individual listening, and walking or wheeling outside. The May 2024 Terrace Recreation Calendar documented on 5/16/2024 at 2:00 PM there was a live Elvis concert outside under the tent. During an observation on 5/16/24 at 10:37 AM, a sign posted in the elevator documented there was an outdoor Elvis concert under the tent out front of the facility at 2:00 PM and popcorn and cotton candy would be served. 1)Resident #41 had diagnoses including Alzheimer's disease (a type of dementia), major depressive disorder, and generalized anxiety disorder. The 7/6/2023 Minimum Data Set Assessment (a health status assessment tool) documented the resident had severely impaired cognition, it was very important to the resident to listen to music they liked, to be around other people, to do their favorite activities, and go outside to get fresh air when the weather was good. The 6/29/2023 comprehensive care plan documented the resident was admitted to the facility for long term care. Interventions included to encourage the resident to participate in activities of choice. The resident required assistance of 1 with all aspects of care including transfers and ambulation. The resident ambulated with a rolling walker and staff assistance or wheelchair with staff assistance. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/10/2023 activities comprehensive care plan documented to provide and review the program calendar to help identify activities of interest, respect refusal, and re-approach. The resident liked music. A 1/4/2024 Director of Activities progress note documented the resident was able to voice their leisure interests to staff when asked or promoted. The resident needed staff to encourage them and bring them to groups. They liked to be around others, would attend live music, singalongs, and socials. Recreation staff would continue to invite them to attend groups. The 4/3/2024 activities quarterly assessment completed by activity aide #39 documented the resident's hearing was adequate and they participated in group activities both large and small. The resident needed reminders, encouragement, and cuing/redirection. Their activity preferences included entertainment/music, social hours, and outdoors. The resident needed staff to encourage them and bring them to groups. The resident enjoyed being around others, and attending live music and singalongs. Recreation staff was to continue to invite them to attend groups. During an observation on 5/16/24 at 2:20 PM, Resident #41 was inside on the unit and asked, What do we do now?. The resident stated they would love to go outside. Resident #41's May 2024 activity log did not document they had gone outside or attended live music entertainment on 5/16/2024. 2) Resident #109 had diagnosis including Parkinson's disease (a progressive neurological disorder) and Alzheimer's disease (a form of dementia). The 5/19/2023 Minimum Data Set Assessment documented the resident had severely impaired cognition, the resident felt it was very important for them to listen to music they liked, somewhat important to do things with groups of people, very important to attend favorite activities, and to go outside to get fresh air when the weather was good. The 5/13/2023 comprehensive care plan documented the resident had cognitive deficits and staff would anticipate and meet the resident's needs and speak slowly and clearly, allowing the resident adequate time to process information. The resident required assistance with all aspects of care and was non-ambulatory. The resident required assistance with wheelchair mobility. The updated 5/22/2023 activities comprehensive care plan documented to provide and review the program calendar with the resident to help identify activities of interest and respect refusal and re-approach. The resident liked music. A 5/13/2024 Director of Activities progress note documented the resident could answer simple questions. They joined groups but required redirection and cueing. The resident enjoyed attending live music. The resident also would people watch. Recreation staff was to continue to invite and encourage them to attend groups of interest. The 5/13/2024 activities annual assessment completed by the Director of Activities documented the resident had normal hearing, semi-actively participated in activities, needed encouragement, cueing, and transportation. The resident enjoyed entertainment/music and social hours. On 5/16/2024 at 2:39 PM, the resident was observed seated in their chair in the television lounge on the unit. At 2:43 PM, the television signal went out. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #109's May 2024 activity log did not document they had gone outside or attended live music entertainment on 5/16/2024. 3) Resident #119 had diagnoses including Parkinson's disease (a progressive neurological disorder) and neurocognitive disorder with Lewy bodies (a type of dementia). The 10/13/2023 Minimum Data Set Assessment documented the resident had severely impaired cognition, enjoyed listening to music, doing things with groups of people, and participating in favorite activities. The 10/6/2023 comprehensive care plan documented the resident was admitted to the facility for long term care. Interventions included to encourage the resident to participate in activities of choice. The resident had cognitive deficits related to their diagnoses and exhibited impaired long term and short memory loss. Interventions included to speak slowly and clearly, allowing the resident adequate time to process information. The resident required assistance with all aspects of care and was independent with mobility. The revised 1/17/2024 activities care plan documented the resident participated in live music and the outdoors. Interventions included provide and review program calendar to help identify activities of interest, respect refusal and re-approach. A 1/17/2024 Director of Activities progress note documented the resident was able to voice their leisure interests when prompted and would occasionally join group activities such as live music, or sometimes would sit in the main areas of the unit and people watch. Recreation staff would continue to encourage them to join groups. The 4/22/2024 Activities quarterly assessment completed by the Director of Activities documented the resident's hearing was normal, they participated in group and individual groups, were a semi-active participant, required encouragement, liked entertainment/music, and outdoors. The resident needed staff to invite them and encourage them to attend groups. They liked attending live music and getting outside. Recreation staff was to continue to invite and encourage them to attend groups of interest. A 5/9/2024 Director of Activities progress note documented the resident had a short attention span, enjoyed musical activities, and socializing with others. During an observation on 5/16/24 at 2:40 PM, the resident was observed seated in a chair on the unit watching television. During an interview with the resident's representative on 5/16/2024 at 3:45 PM, they stated the resident loved music and was a musician. Resident #109's May 2024 activity log did not document they had gone outside or attended live music entertainment on 5/16/2024. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2024 at 10:38 AM activity aide #39 stated the Terrace unit was a locked unit and most of the residents had dementia. The Director of Activities came up with the activity calendar along with resident input. The facility celebrated National Nursing Home Week the prior week. They had special events planned for the week including a live Elvis concert outside under a tent in the front of the building. The activity staff collaborated and came up with a list of residents they determined who would not be appropriate to attend the day of the event. They thought the Director of Activities had a copy of the list. Resident preferences were obtained on admission, annually, and during quarterly assessments by interviewing the residents or resident representatives. It was important for the residents to attend activities of interest for stimulation, quality of life, and enjoyment. Activity staff only documented if the residents attended activities and did not document if they refused to attend events. They were unsure why Resident #119 did not attend the live music event. They stated Resident #41 was asked to attend the event but declined. Resident #109 liked music and going outside, they thought the resident was sleeping in their chair when residents were brought outside. They stated they should have woken Resident #109 up and asked them if they wanted to attend the event. During an interview on 5/22/2024 at 11:04 AM the Activities Director stated the department decided which programs to put on the calendar with the resident's input. The activity staff completed the resident's assessments and obtained their activity preferences on admission, annually, and quarterly via interviews with the resident or their representative. Activities were important for the resident's quality of life and wellbeing. The Terrace Unit was a memory care unit. The Elvis concert was opened to all residents to attend. They did not have list of residents to ask to the event and expected staff to invite all residents as this was a special event for National Nursing Home Week. They had been discussing the event in the facility's morning report for some time and the need for all hands-on deck approach to transport residents. They wanted as many residents as possible to attend the event. They were unsure why the turnout was not as large as they expected, but it was tough getting the residents out with the limited staff they had. They stated they were working with the activity staff to improve their documentation as they did not document refusals at this time. Any resident who enjoyed music and being outdoors should have been offered to attend the activity. 10NYCRR 415.5(f)(1)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49448 Based on observation, record review, and interview during the recertification and abbreviated (NY00320383 and NY00326481) surveys conducted 5/16/2024-5/23/2024, the facility did not ensure residents at risk for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to prevent new ulcers from developing and promote wound healing for 1 of 6 residents (Resident #48) reviewed. Specifically, Resident #48 developed moisture associated skin damage (open areas resulting from moisture on the skin) on 2 occasions when incontinence care was not provided routinely or as planned. Findings include: The facility policy, Incontinent Product Usage/ Attends Briefs created 8/2014 documented residents were cared for incontinence with a program that promoted healthy skin and kept residents dry and comfortable, while their dignity was maintained, and their quality of life was improved. Incontinence briefs were checked frequently for wetness and changed when soiled. Any redness, rashes, or blisters were reported to the charge nurse and all residents were monitored per their care plan. The facility policy, Toileting Residents created 8/2015 documented the registered nurse indicated the time frames a resident was toileted on the personal care sheet. The time frame reflected the individual needs of the resident on a 2-4 hour basis and as needed during the night. This was recorded in the personal care record. The certified nurse aide initialed the correct space that indicated the time the resident was toileted. The facility policy, Wound Identification and Wound Rounds revised 11/6/2023 documented the facility identified, assessed, and managed residents with pressure injuries, skin alterations, impairments, or wounds in accordance with current standards of practice. For newly identified pressure injuries, skin alterations, impairments or wounds, the licensed nurse completed a head-to-toe skin evaluation. The registered nurse completed a skin assessment that included documentation of size, depth, and stage if applicable and appearance of the skin impairment. The licensed nurse notified the health care provider and obtained a treatment order. The wound nurse developed the care plan for the new skin impairment and included prevention interventions as necessary. The licensed nurse performed a weekly and as needed skin monitoring and documented their finding in the electronic medical record. Resident #48 had diagnoses including Alzheimer's disease (a type of dementia) and urinary incontinence. The 4/28/2024 Minimum Data Set Assessment (a health assessment tool) documented the resident had severely impaired cognition, was dependent on staff for toileting, hygiene, bed mobility and transfers with a mechanical lift, was a risk for pressure ulcers, had applications of ointments/ medications other than to feet, had a pressure reducing device for the bed and chair, and did not reject care. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan initiated 1/6/2021 and reviewed 12/28/2023 documented the resident was at high risk for skin breakdown related to decreased mobility and incontinence. Interventions included incontinence care, certified nurse aide to report skin conditions daily during care and report any abnormalities to the nurse, maintain turn and position schedule every 2-4 hours, and use skin protectant/barrier when performing perineal care (washing genital and rectal areas). The resident exhibited impaired long term and short-term memory, limited judgement, and safety awareness. Interventions included repeat/rephrase as needed, give simple cues, and staff anticipated and met any unexpressed needs. The 10/1/2023 through 10/16/2023 certified nurse aide documentation of care provided contained no documentation the resident was provided with incontinence care on 11 of 16 dates (16 of 48 shifts). The 10/18/2023 Assistant Director of Nursing's progress note documented the resident had a 3.5 centimeter by 2 centimeter open area to the left buttock and a 3.5 centimeter by 2 centimeter open area to the right buttock that would be treated with ointment that removed dead tissue. The 10/2023 Treatment Administration Record documented: - Initially ordered on 1/3/2023, zinc cream to coccyx (tailbone) twice daily and as needed. - A new order on 10/18/2023, cleanse open areas on the left and right buttocks with normal saline, pat dry, and apply topical ointment once daily. The 10/19/2023 Licensed Practical Nurse Unit Manager #17's progress note documented a referral to the wound care center. The 10/27/2023 Physician #15 offsite wound care center's initial visit note documented an injury to the perineum (area between the rectum and the genitals) from shearing from the chair, and fecal incontinence. Treatment included: cushion to wheelchair, place resident on their side in bed part of the day/spend more time in bed than chair, turn and reposition every 2 hours, changing incontinence briefs, and zinc oxide treatment with a component that adheres to wet skin/for incontinence, sensitive areas to bilateral buttocks wounds daily. The 10/2023 Treatment Administration Record documented the collagenase (ointment that removes dead tissue) treatment to the resident's buttocks was discontinued on 10/28/2023. The 12/6/2023 Physician #15 offsite wound care center's visit note documented the continued recommended treatment of bilateral buttocks wounds was zinc oxide treatment with a component that adheres to wet skin/for incontinence. The 12/2023 Treatment Administration Record documented: - zinc oxide cream continued to the resident's coccyx twice daily and as needed. - a new order, dated 12/29/2023, zinc oxide treatment with a component that adheres to wet skin/for incontinence, sensitive areas to the left and right buttocks daily. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From 10/27/2023 through 3/6/2024, the resident was seen by the outside wound care center. The 2/14/2024 offsite wound care center's visit note by Physician #15 documented no treatment changes but keep the resident off their right buttock. The 3/6/2024, Physician #15's note documented the resident no longer had wounds to the buttocks. The care instructions (used by direct care staff to provide care) documented the resident's incontinence brief was to be changed every 2 hours starting on 3/11/2024. The 5/1/2024 Physician #15 offsite wound care center's visit note documented the resident should be followed by the facility wound care team and could see the offsite wound care center for urgent needs. The 5/9/2024 and 5/16/2024 Nurse Practitioner #16's weekly wound round notes did not document any skin issues to the buttocks. The 5/2024 Treatment Administration Record documented: - zinc oxide cream continued to the coccyx twice daily and as needed. - zinc oxide treatment with a component that adheres to wet skin/for incontinence to the left and right buttocks daily. From 5/1/2024-5/19/2024 the certified nurse aide documentation did not include documented evidence the resident was provided with incontinence care for 17 of 19 days (32 shifts). Observations of Resident #48 included: - on 5/16/2024 at 10:21 AM, sitting in a medical positioning wheelchair in the common area of the unit and at 4:14 PM, sitting in the medical positioning wheelchair in the common area of the unit with a urine odor noted on the resident. - on 5/17/2024 at 8:33 AM and 12:53 PM, sitting in a medical positioning wheelchair in the dining room. At 1:13 PM, staff wheeled the resident to the common area and placed them in front of the television. The resident remained in a medical positioning wheelchair in front of the television until 3:01 PM. - on 5/20/2024 at 8:18 AM sitting in a medical positioning wheelchair in the dining room for breakfast. At 9:52 AM, the resident was brought to the common area and placed in front of the television. At 10:15 AM, they were taken to a hair appointment in the medical positioning wheelchair. At 11:03 AM, they returned from the hair appointment and was placed in front of the television in the common area. They remained in the common area until 11:49 AM when they were wheeled to their room for incontinence care. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/20/2024 at 11:54 AM, Certified Nurse Aides #20 and #21, and Licensed Practical Nurse #18 provided incontinence care to the resident. The resident's incontinence brief was saturated with urine and was removed. The mechanical lift pad (used to transfer a resident with a mechanical lift) was soiled with many areas of dried fecal matter was removed and replaced. A reddened area approximately the size of a ping pong ball was noted to the medial right buttocks. Licensed Practical Nurse #18 stated this area was reported to them that morning by an unidentified certified nurse aide and they had not seen it yet. They stated the resident had a treatment of zinc ointment for prevention. They left the room to get the Assistant Director of Nursing. Licensed Practical Nurse #18 returned to the room with the Assistant Director of Nursing, who reported this area to the buttocks was new and this was moisture associated skin damage. The resident had moisture associated skin damage in the past that had resolved. Licensed Practical Nurse #18 applied the ordered zinc ointment to the resident's buttocks per the direction of the Assistant Director of Nursing. Nursing progress notes through 5/21/2024 did not include documentation of the presence of the new skin issue on the resident's buttock. During a continuous observation on 5/21/2024 from 8:49 AM until 2:22 PM, Resident #48 was not provided with incontinence care/toileting. At 8:49 AM, the resident was in their medical positioning wheelchair in the dining room for breakfast; at 9:39 AM, the resident was wheeled into the common area and placed in front of the television; at 11:40 AM, the resident was wheeled into the dining room; at 12:42 PM, the resident was wheeled to the common area in front of the television; and at 1:54 PM, the resident was wheeled to the music activity near the nursing station. During an interview on 5/21/2024 at 1:47 PM Certified Nurse Aide #22 stated they reported any new skin issues to the unit licensed practical nurse or Licensed Practical Nurse Unit Manager #17. It was important to report skin issues so the wound would not get worse or get infected. Residents were toileted every 2-4 hours whether they were continent or incontinent. Resident #48 was incontinent. They provided incontinence care to them before breakfast when they got them out of bed that morning around 7:30 AM. They had not provided incontinence care to Resident #48 since then because they were busy. Certified Nurse Aide #22 stated the resident was at risk for skin breakdown and used to have a sore on their buttocks that recently healed. It was important they were toileted frequently for urinary tract infection prevention, for dignity, and for prevention of skin breakdown. They stated it was also important to check incontinence regularly on Resident #48 because they could not advocate for themselves. During a telephone interview on 5/22/2024 at 8:48 AM the resident's representative (designated on the face sheet as the resident's emergency contact person) stated in 10/2023, they observed wounds on the resident's buttocks. At that time, they requested the resident go to the wound care clinic because they did not feel the facility monitored skin closely. The wound care clinic provided a cream for the resident's buttock wounds and the wounds cleared up. They were not aware of any current wounds to the buttocks. When they came to visit the resident, the resident was often sitting up in their chair. They stated they regularly requested incontinence care upon arrival because they could smell incontinence odors on the resident and the incontinence brief was normally saturated when it was changed. They stated they felt the resident was probably soiled all day, regularly. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at 9:46 AM Licensed Practical Nurse #19 stated if a new skin issue was reported to them, they would look at it and report it to Licensed Practical Nurse Unit Manger #17. Certified nurse aides were expected to look at the skin when care was provided. Residents were toileted every 2-4 hours and as needed. Incontinence care was important for dignity, illness/infection prevention, and good hygiene. If a resident was a risk for pressure ulcers, they should be provided with incontinence care closer to every 2 hours and turned and repositioned. If they were not, it could create pressure or make it worse. It was not appropriate for anyone to be in the same incontinence brief for 6-7 hours as it promoted skin breakdown. Resident #48 was incontinent and at risk for pressure ulcers and should be provided with incontinence care regularly. The resident was not able to tell staff if they were soiled. During an interview on 5/22/2024 at 10:07 AM Licensed Practical Nurse Unit Manager #17 stated when a new skin issue was reported to them, they let the Assistant Director of Nursing know and then the resident would be seen by Wound Nurse Practitioner #16. It was important the certified nurse aides reported new skin issues so they could be addressed and prevent infection. If they were not made aware of new skin issues, they could worsen. All residents were toileted or provided with incontinence care every 2-4 hours for urinary tract infection prevention and wound prevention. If Resident #48 was not provided with incontinence care, it could lead to pressure sores. They had been made aware of a new sore to the resident's buttocks and the resident seated in their chair for 6-7 hours without having their incontinence brief changed could have contributed to the new sore. During an interview on 5/22/2024 at 10:42 AM the Assistant Director of Nursing stated they rounded with Wound Nurse Practitioner #16 weekly. Resident #48 was incontinent and at risk for pressure ulcers. They stated they first noticed moisture associated skin damage to Resident #48 on 10/18/2023 and that had since resolved. The resident was supposed to be provided with incontinence care every 2-4 hours. If the resident was not provided with frequent incontinence care moisture associated skin damage could occur. The new sore from 5/20/2024 was also moisture associated skin damage. Certified nurse aides were expected to check skin with shower days and with daily care and report any abnormalities. Skin issues should be caught early if the resident's skin was checked every 2-4 hours when care was provided. Any new skin issues were reported to a nurse and then the Assistant Director of Nursing would assess the new area and place the resident on the list to be seen by the wound nurse practitioner and update the wound nurse practitioner of the new skin issue. The resident was scheduled to be seen again by wound Nurse Practitioner #16 on 5/23/2024 who would assess the moisture associated skin damage to their buttocks at that time. During an interview on 5/22/2024 at 2:08 PM, Wound Nurse Practitioner #16 stated they were not notified of a new skin issue with Resident #48. They stated if there was a new skin issue on an already established patient of theirs, they were notified of new skin issues when they rounded on Thursdays. They had started to care for Resident #48 a few weeks ago as the offsite wound center had deferred to onsite wound care. They stated they only looked at healed wound areas if a concern was brought to their attention. Moisture associated skin damage was exactly what the name implied. Interventions for prevention included barrier cream and incontinence care. If Resident #48 was soiled for 6-7 hours, it could cause moisture associated skin damage and could lead to pressure sores. Incontinence care should be provided per facility policy. 10NYCRR 415.12(c)(1)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 40803 Based on observation, record review, and interview during the recertification survey conducted 5/16/2024-5/23/2024, the facility did not ensure residents were assessed for risk of entrapment from bed rails prior to installation, did not review the risks and benefits of bed rails with the resident or resident representative, and did not obtain informed consent prior to the installation of bed rails for 4 of 4 residents (Resident #48, #59, #109, and #119) reviewed. Specifically: - Resident #109 had no documented evidence of a bed rail assessment prior to bed rail installation, explanation of the risks and benefits of bed rails to the resident or their representative, or consent prior to bed rail installation. Additionally, the resident's enabler bar was not removed timely, and the resident was found with their arm between the enabler bar and the mattress. - Residents #48, #59 and #119 had no documented evidence of a bed rail assessment prior to bed rail installation, explanation of the risks and benefits of bed rails to the resident or their representative, or consent prior to bed rail installation. Findings include: The undated facility policy, Use of Bed Enablers documented the use of bed enablers would be carefully considered and justified based on individual resident needs. Therapy would complete an assessment on admission and upon receiving a therapy evaluation from nursing. Careful attention for risk factors such as fall risk, mobility, cognitive status, and individual preferences would be taken into consideration before implementing. Therapy would send a work order to maintenance for the application of the bed enabler(s) per manufacturer instructions. Nursing staff would be responsible for documentation and care planning the use of the enabler device(s) and adding the information to the certified nurse aide care assignment sheet. 1) Resident #59 had diagnoses including spinal stenosis (spaces between the bones of the spine are narrowed) of the thoracic (mid back) region and chronic pain. The 4/26/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, functional limitation in both legs, required substantial/maximal assistance with rolling left to right, and was dependent for sit to lying and chair to bed transfers. The resident had falls prior to admission. The 3/20/2024 comprehensive care plan documented the resident was at risk for falls. Interventions included answer call bell promptly, keep call bell within reach, and mattress next to bed. On 5/8/2024 the resident was at risk for skin breakdown and interventions included to provide left and right bed enabler bars to assist with positioning and comfort. The 4/7/2024 Fall Risk Assessment documented the resident was at high risk for falls. On 4/8/2024 at 9:44 AM, the Director of Therapy sent an electronic mail to the Director of Nursing regarding the residents who needed or had bed enabler devices and were safe/ appropriate for use and Resident #59 was not included. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations on 5/16/24 at 12:18 PM and 5/17/24 at 8:44 AM there were 1/4 bed rails on both sides of the resident's bed. There was no documented evidence of a bed rail assessment prior to bed rail installation, that the risks and benefits of bed rails were explained to the resident or their representative, or that consent was obtained prior to bed rail installation. During an interview on 5/21/2024 at 11:01 AM Certified Nurse Aide #32 stated that Resident #59 had bed enabler bars on both sides of their bed, and they used them for positioning. The resident had a safety mat on the floor and had falls in the past. The bed enabler bars were not listed on the certified nurse aide assignment sheet. During an interview on 5/21/2024 at 12:35 PM the Director of Therapy stated the resident was able to use the bed enabler devices for positioning and was care planned for their use. The enabler bars could be a possible safety risk if the resident did not use them correctly. They did not review the risks or benefits with the resident's representative and did not obtain informed consent prior to installation of the enabler bars. 2) Resident #119 had diagnosis including Parkinson's disease (a progressive neurological disorder), neurocognitive disorder with Lewy body dementia, and repeated falls. The 1/23/2024 Minimum Data Set Assessment documented the resident had severely impaired cognition, had functional limitation of one arm, required supervision or touching assistance with rolling left to right, sit to lying, lying to sitting on side of bed, sit to stand, and chair to bed transfers. The resident had 2 falls without injury and 2 falls with injuries (expect major injuries) since admission/entry or reentry or the prior assessment and did not use any restraints or alarms. The 10/6/2023 comprehensive care plan documented the resident had cognitive deficits related to Lewy body dementia and had impaired long term and short-term memory, limited judgement, and safety awareness. The resident required assistance with all aspects with care. The resident required assistance with bed mobility and transferred with staff assistance. The resident was at risk for falls related to their cognitive deficits. Interventions included use appropriate devices and level of assistance as recommended. The resident was at risk for skin breakdown and the updated 5/8/2024 interventions included to provide a left side bed enabler device to assist with positioning and comfort. The 3/24/2024 Fall Risk Assessment documented the resident was a high risk for falls. During an observation on 5/16/24 at 10:12 AM the resident was in their room in bed. There was a 1/4 bed rail on the right side of the bed. There was bruise on the resident's right arm just above elbow. The updated 5/22/2024 certified nurse aide assignment sheet documented the resident was independent with bed mobility. It did not include the use of an enabler bar. There was no documented evidence of a bed rail assessment prior to bed rail installation, that the risks and benefits of bed rails were explained to the resident or their representative, or that consent was obtained prior to bed rail installation. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/2024 at 12:56 PM the Director of Therapy stated the resident could use the bed enabler device. The enabler bars could be a possible safety risk if the resident could not use them correctly. They did not review the risks or benefits with the resident's representative and did not obtain informed consent prior to installation. 3) Resident #109 had diagnoses including Parkinson's disease (a progressive neurological disorder), Alzheimer's disease (a type of dementia), and repeated falls. The 2/17/2024 Minimum Data Set Assessment documented the resident had severely impaired cognition, rejected care 1- 3 days, and wandered 1- 3 days. The resident had functional limitation of both legs, was dependent for rolling left to right, lying on the side of the bed, sit to stand, and chair/ bed to chair transfers, had 2 or more falls since admission/entry or reentry or prior assessment with no injury, and used both a bed and chair alarm daily. The 5/12/2023 comprehensive care plan documented the resident had impaired short and long-term memory, limited judgement and safety awareness related to Parkinson's Disease and Alzheimer's Dementia. The resident had a vision deficit related to the aging process and cognitive deficits. The resident had an activity of daily living deficit and required assistance with all aspects of care including bed mobility assistance of 2, transfer assistance of 2, and was non ambulatory. The resident was at risk for falls and interventions included the use appropriate assistive devices and level of assistance as recommended. The care plan did not include the use of a bed enabler device. The 3/29/2024 certified nurse aide assignment sheet did not include the use of enabler bars. On 4/1/24024 at 8:58 AM, the Director of Therapy sent an electronic mail to the Maintenance Director with a list of residents that needed their bed enabler bars removed, Resident #109 was on the list. There was no documented evidence in the resident's record of a bed rail assessment prior to bed rail installation, that the risks and benefits of bed rails were explained to the resident or their representative, or that consent was obtained prior to bed rail installation. The facility's 4/8/2024 Accident and Incident report documented to refer to the 4/9/2024 progress note completed by Registered Nurse Supervisor #30. Staff statements included: - Licensed Practical Nurse #31's statement documented the time of the incident was the first time they saw the resident that evening (at 11:50 PM). The care plan was followed, and the resident leaned a lot and was shaky due to Parkinson's Disease. The certified nurse aides found the resident lying half on and half off their bed with their head on the bed and feet/ legs on the mattress on the floor. The resident's right arm was pressed against the metal railing of the bed and a skin tear was found on their left arm. - Certified nurse aide #32's statement documented they did not see the resident until they found them. At the time of the incident, they were completing their rounds, the care plan was followed, the resident usually reaches for things, there was no change in their activity of daily living functions, and it looked like they were in that position for hours. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Certified nurse aide #33's statement documented they last saw the resident at the start of their shift during rounds in the resident's room. The resident was observed to be leaning off the bed with their head on the bed and their arm was wedged between the (bed) rail and the mattress. The resident's legs were on the mattress on the floor. The care plan was followed. The resident was known to get up and climb out of their bed. The resident had a cut on their left arm and their right arm was discolored from being wedged. On 4/9/2024 at 11:50 PM Registered Nurse Supervisor #30 documented on 4/8/2024 at 11:30 PM, the resident was found lying halfway out of their bed. Their upper torso was on the bed and their lower extremities were on the floor mattress. Staff reported their right arm was pressed against the bed and the enabler bar on the outside of the bed. The right arm was reported by staff as cold but at the time of the assessment the arm was warm to the touch with normal capillary refill. The care plan was followed and there were no apparent injuries noted. The provider would be notified in the morning and family was notified. A new order was obtained to initiate fall protocol and monitoring. No signs of abuse, neglect or mistreatment were identified, and nursing would continue to monitor. There was no documented evidence the enabler bar usage was reviewed after the incident despite therapy's request for removal on 4/1/2024. During an interview on 5/21/24 at 12:28 PM the Director of Therapy stated the therapy department determined if a resident needed enabler devices for positioning on their bed. The residents were evaluated for bed positioning upon admission and when they were receiving therapy services. If a resident was physically able to use the enabler device, therapy would send an electronic mail to the maintenance department who then installed the device. Therapy staff also determined if the devices were no longer needed. In the past both nursing staff and the therapy department reviewed the risks and benefits of bed rails with the resident or resident representative. They were unsure who obtained informed consent prior to the installation of the enabler devices. They thought the nursing staff added the enabler devices to the care plan. They stated on 4/1/2024 they completed a full house audit on residents who had enabler devices on their beds and requested that Resident #109's be removed as the resident was unable to follow commands and it was not safe. The resident was cognitively impaired, and it posed a possible safety risk. The Maintenance Director was notified via electronic mail of the request for removal. They were unaware the enabler device was still installed on the bed on 4/8/2024. During an interview on 5/17/2024 at 1:11 PM Registered Nurse Unit Manager #14 stated they thought nursing staff monitored the resident's ability to use the enabler devices installed on their bed. They were unsure who reviewed the risks and benefits of bed rails with the resident or resident representative. They were unsure who obtained informed consent prior to the installation of the enabler devices. They stated only residents who were able to use the enabler devices had them installed on their beds. Therapy recommended the use and discontinuation of the enabler devices and the maintenance staff installed and removed the devices. Resident #109 no longer had an enabler device installed on their bed and they were unsure if the resident was ever care planned for the use of the enabler device on their bed. They did not recall the 4/8/2024 incident when the resident was found with their arm between the enabler device and their mattress. They stated incident reports were reviewed by the interdisciplinary team during the report and the team reviewed care plan interventions. They stated enabler bed devices posed a possible safety risk for entrapment. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Maintenance on 5/21/2024 at 2:04 PM, they stated the therapy department notified them of which resident needed bed enabler devices installed or removed via electronic mail. They stated they received an electronic mail notification that documented Resident #109 needed their bed enabler devices removed on 4/1/2024 at 8:58 AM and again on 4/11/2024 at 3:10 PM. The bed enabler device should have been removed on 4/1/2024, but they did not have documented evidence the bed enabler device was removed until after the 4/11/2024 notification. Bed enabler devices posed a risk for injury, and it was important to remove the requested equipment for safety reasons. The facility checked the bed enabler devices during their monthly audits. During an interview on 5/21/2024 at 4:06 PM the Assistant Director of Nursing stated the therapy department determined if a resident could benefit from the use of a bed enabler device. Maintenance staff installed the device on the bed. They were unsure who reviewed the risks and benefits of bed rails with the resident or resident representative. They were unsure who obtained informed consent prior to the installation of the enabler devices. Nursing staff was responsible for updating the care plan if a resident used bed enabler devices and nursing or therapy could request the removal of the device. Nursing staff received notification on the installation and removal of bed enabler devices and therapy was responsible to ensure the devices were removed. They recalled the 4/8/2024 incident when Resident #109's arm was found pressed against their bed enabler device and mattress. They stated a request was made for the device to be removed and it was not done. If therapy determined the resident no longer could use the bed enabler device, it was a safety risk for the resident. During a telephone interview on 5/22/2024 at 1:22 PM Certified Nurse Aide #33 stated on 4/8/2024 they were completing their first rounds of the shift with another certified nurse aide. They observed the resident half on and half off their bed with their arm between the bed enabler device and mattress. They moved the resident's arm prior to the nursing supervisor coming to assess to the resident. They told the nursing supervisor what they saw when they found the resident and wrote a statement. They thought bed enabler devices were care planned but could not recall if Resident #109 had a bed enabler device on their care plan. 10NYCRR 415.12(h)(1)(2) 49448		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 35045 Based on observation, record review, and interview during the recertification and abbreviated (NY00320383 and NY00326481) surveys conducted 5/16/2024-5/23/2024, the facility did not post daily, the current resident census and the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, accessible to residents and visitors for 4 of 6 days reviewed. Specifically, the current daily resident census was not documented, and the licensed nurse staffing was not divided into licensed practical nurses and registered nurses for each shift in a 24-hour period. Findings include: The undated facility policy, Staffing Plan documented the facility provided 24-hour nursing services sufficient to meet the total nursing needs of the residents. Daily staffing sheets were completed by the night nursing supervisor and posted in the lobby. The daily resident census and nurse staffing information was observed posted to the right of the front receptionist desk: - on 5/16/2024 at 9:30 AM. - on 5/17/2024 at 8:28 AM. - on 5/20/2024 at 8:30 AM. - on 5/21/2024 at 8:30 AM. The posting did not include the daily census and did not include the total number and actual hours worked per shift for registered nurses, licensed practical nurses, and certified nurse aides that were responsible for resident care. During an interview on 5/21/2024 at 1:26 PM, the Administrator stated they were not aware the posted staffing should include separate shifts, and separate hours for the licensed staff. They were not aware the census was not listed on the current postings. They stated it was important and provided transparency to the residents and families of the type and quantity of care gives the facility provided to the residents. 10 NYCRR 415.13		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35045 Based on observation and interview during the recertification survey conducted 5/16/2024-5/23/2024, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for 1 of 3 medication carts (second floor Ridge cart), and 1 of 2 medication rooms (first floor) reviewed. Specifically, the second floor Ridge medication cart was unlocked and unattended; and the first floor medication room had 3 bottles of alcoholic beverages stored in a brown paper box on the floor. Findings include: The facility policy, Medication Storage Policy last revised 4/2024, documented all drugs would be stored in locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. The facility policy, Medication Administration last revised 10/11/2023 documented the medication carts were to always be locked when not in use for medication administration; and locked and stored in a non-resident area on the unit when not in use for medication administration passes. The facility policy Resident Use of Alcoholic Beverages created 4/2011 documented residents who wished to consume alcoholic beverages on premises would have an order for use of alcoholic beverages by the attending physician or nurse practitioner. Medication Carts: During an observation on 5/17/2024 at 8:38 AM, a medication cart located on the second floor Ridge hallway was left unlocked and unattended for two minutes. There was no nurse in sight. During an observation on 5/17/2024 at 2:48 PM, an unattended, unlocked medication cart was in the hallway of second floor Ridge unit. There were no nurses in sight. During observation on 5/20/2024 at 8:35 AM, an unattended, unlocked medication cart was in the hallway outside the dining room of the second floor Ridge unit. Licensed Practical Nurse #3 returned to medication cart briefly, then left the cart unlocked to administer medications to a resident who was in the dining room. During an interview on 5/20/2024 at 9:12 AM, Licensed Practical Nurse #3 stated medication carts should be locked, and the computer screens should be closed anytime they walked away from the cart or turned their back to the cart. It was important to do this as staff, residents, or visitors could get into their cart and take something. If someone were to take a medication it could cause harm or illness. They were aware they had left the cart unattended and unlocked. They were pulled away from what they were doing by staff and residents. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/20/2024 at 11:13 AM, Licensed Practical Nurse #8 unlocked the medication cart that was located outside of room [ROOM NUMBER] on the second floor Ridge unit, walked away, entered the dirty utility room, and then returned to the medication cart. Licensed Practical Nurse #8 stated the medication cart was supposed to be locked when not in their vision. The medication cart should be always locked when not in use to keep the medications safe and ensure the residents did not take any medicine they should not have. During an interview on 5/22/2024 at 8:55 AM, Licensed Practical Nurse Manager #1 stated all medication carts should be locked and tethered when the nurse was not physically going through the cart. It was important medication carts were locked so others did not remove and take any medications. This could cause harm or illness to someone. Medication room with Alcoholic Beverages: During an observation of the unit one medication storage room on 5/20/2024 at 3:38 PM with Licensed Practical Nurse #24, there was a cardboard box on the floor with a half empty 750 milliliter bottle of chardonnay wine labeled with Resident #75's name; an unopened, unlabeled 750 milliliter bottle of cabernet wine; and an unlabeled half empty 1750 milliliter bottle of brandy. Licensed Practical Nurse #24 stated they did not think the alcohol should be stored on the floor, but it had been stored there for the year that they had been employed at the facility. All alcohol should be labeled with the resident's name. During an interview on 5/22/2024 at 10:07 AM, Licensed Practical Nurse Unit Manager #17 stated residents could have alcohol if they had an order for it. All alcohol bottles should be labeled just like a medication. Resident #75 had a labeled bottle of wine in the medication room, and they did not have an order for it, but should have. Resident #28 did have an order for brandy. It was important that alcohol was labeled and verified the same way as medications were, the right resident and the right drink order. During an interview on 5/22/2024 at 10:42 AM, the Assistant Director of Nursing stated alcohol was locked in the medication room and required an order just like any medication. It was supposed to be labeled with the resident's name. 10NYCRR 483.45 (g)(h) 49448 50561		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 27522 Based on record review, observation, and interview during the recertification and abbreviated (NY00311928) surveys conducted 5/16/2024-5/23/2024, the facility did not ensure planned menus were followed for 2 of 2 residents (Resident #23 and #117) reviewed. Specifically, Residents #117 and #23 did not receive menu items as planned per their individual meal tickets. Findings include: The undated facility policy, Meal Delivery documented dietary staff were responsible to ensure that all items were placed on the meal tray as indicated on the meal ticket, including requested condiments. During an observation on 5/17/2024 at 1:23 PM, Resident #117's lunch tray was delivered to their room, used for a test tray, and a new tray was ordered for the resident. The original tray ticket documented the resident was to receive peppers, matzo ball soup, and gravy. None of these items were on Resident #117's tray. During an observation on 5/20/2024 at 12:38 PM, Resident #23's lunch tray was the last tray in the hot box brought from the kitchen. The resident's meal was used to for a test tray, and a new tray was ordered for the resident. The original tray ticket documented the resident was to receive a pineapple cup. The pineapple cup was not on Resident #23's tray. During an interview on 5/22/2024 at 9:26 AM, the Food Service Director stated in the main kitchen there was a dedicated staff member who checked the meal tickets (menus) during the food plating process and ensured all food items were on the resident trays. They stated prior to a resident tray being served, a nurse on the floor verified the food items on the ticket and the food items on the tray matched. The Food Service Director stated if there were missing food items staff should call the main kitchen for what was missing. They stated there had been some resident complaints in the past regarding missing food items, and they had completed test trays and audits. They stated there were no recent complaints about this issue. 10NYCRR 415.14(c)(1-3)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 27522 Based on record review, observation, and interview during the recertification and abbreviated (NY00311928) surveys conducted 5/16/2024-5/23/2024, the facility did not ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 meals (lunch meals on 5/17/2024 and 5/20/2024) reviewed. Specifically, food was not served at palatable and appetizing temperatures for lunch on 5/17/2024 and 5/20/2024. Findings include: The undated facility policy Palatability documented hot food was served at no less than 140 degrees Fahrenheit after following proper cooking. Cold food was served at no higher than 40 degrees Fahrenheit after following proper procedure for portioning, holding, and storage. Carts were plugged in on the floors and maintained temperature during tray pass for each meal to maintain a meal temperature palatable to most residents. During an observation on 5/17/2024 at 1:23 PM, Resident #117's lunch meal tray was delivered to their room, used for a test tray, and a new tray was ordered for the resident. At 1:24 PM, the food temperatures on the tray were measured with the following results: the French fries were 91 degrees Fahrenheit, the ground fried chicken was 106 degrees Fahrenheit, the mixed vegetables were 106 degrees Fahrenheit, and the apple juice was 61 degrees Fahrenheit. The French fries, ground fried chicken, mixed vegetables, and the apple juice were not served at palatable temperatures. During an observation on 5/20/2024 at 12:38 PM, Resident #23's lunch meal tray was the last tray in hot box brought from the kitchen, used for a test tray, and a new tray was ordered for the resident. At 12:44 PM, using a kosher approved thermometer, the food temperatures on the tray were measured with the following results: the mashed potatoes were 117 degrees Fahrenheit, the soup was 108 degrees Fahrenheit, the beef stew was 106 degrees Fahrenheit, and the cabbage was 90 degrees Fahrenheit. The mashed potatoes, soup, beef stew, and cabbage were not served at palatable temperatures. During an interview on 5/22/2024 at 9:17 AM, the Food Service Director stated the food service management team did test trays a couple of times a week, and that three test trays and 14 audits food had been completed for April 2024. They stated residents had complained during resident council about cold food. Staff were told to keep the hot box doors closed when not being used and to keep the hot boxes plugged in. The Food Service Director stated that hot food was palatable at 115 degrees Fahrenheit to 135 degrees Fahrenheit depending on the individual resident preference. Cold food shelf stable items should be served at 40 degrees Fahrenheit to 50 degrees Fahrenheit. They stated the temperatures of the French fries, the ground fried chicken, the mixed vegetables, the apple juice, the soup, the beef stew, and the cabbage were not palatable temperatures. The Food Service Director stated it was important that all cold and hot food items were maintained at palatable temperatures. 10NYCRR 415.14(d)(1)(2)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 27522 Based on record review, observation, and interview during the recertification and abbreviated (NY00311928) surveys conducted [DATE]-[DATE], the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen, and 1 of 3 unit kitchenettes (Terrace unit kitchenette). Specifically, in the main kitchen the ventilation hood system was missing a grease trap, there were multiple stained ceiling tiles, there was a hole in one of the kitchen walls with exposed wiring, the meat side of the freezer floor was in disrepair, and there was expired and undated food; and the Terrace unit kitchenette had expired and undated food. Findings include: The facility policy, Guidelines for Receiving and Stock Rotation, revised [DATE], documented the code date on products was noted: best before date, expiration date or use by date; and stock was rotated so that old stock was used before the new stock. The facility Daily Cleaning Schedule documented the meat side freezer was swept and mopped daily. The following was observed in the main kitchen on [DATE], between 9:15 AM and 10:15 AM: - the dairy side cooler had 11 half pints of low-fat milk dated [DATE], and two half pints of chocolate milk dated [DATE]; - the ventilation filters for the dairy side hood system were missing a grease trap; - near the dairy side three bay sink there was an 8 foot x 10 foot section of the ceiling that was stained with miscellaneous debris; - a wall in between the dairy side of the main kitchen and the meat side of the main kitchen had a one inch circular hole with exposed wires inside which could get wet when the wall was cleaned; - the dirty side of the dish machine had three stained 2 foot x 4 foot ceiling tiles; - the meat side blender area had two stained 2 foot x 4 foot ceiling tiles; - the meat side cooler had two 6 packs of poppyseed bagels, one 6 pack of plain bagels, and one 6 pack of sesame bagels that were not dated; - the floor in the meat side freezer had a section of flooring that was lifted, unsafe, and was a tripping hazard; - the meat side bread rack had loaves of bread dated [DATE] and [DATE], a sweet rye bread dated [DATE], an undated marble rye bread, and an opened club wheat bread dated [DATE]. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 9:37 AM, with the Food Service Director present, the Terrace unit kitchenette non-kosher refrigerator contained a half round cake that was dated [DATE], an undated container of mashed potatoes, an undated container of chicken salad, a bag of moldy grapes, and a staff blue lunch box. During an interview on [DATE] at 8:50 AM, the Food Service Director stated they were aware of a couple of the stained ceiling tiles in the kitchen. The ceiling tiles had not been cleaned in a few months. They could not verify that maintenance was made aware of the stained ceiling tiles. If a ceiling tile had to be replaced the kitchen staff contacted the maintenance department and it was replaced by a maintenance worker. The Food Service Director was not sure how long the wall had the hole in it, and stated there should be no holes in the lower walls as they were sprayed weekly. They stated they were not sure where the missing grease trap went or when it went missing. The diamond plate floor in the meat side freezer had been replaced three years ago, the height gap had gotten worse over time, and they were not sure if the current Maintenance Director was aware of this. A stock person was responsible to ensure milk was checked for expired dates three times a week. The stock person who worked on [DATE] should have reported there was milk due to expire that day, as well the next day, and should have reported that to a manager. They stated on [DATE], when the facility went into Passover, all the bread was thrown out and was not sure where the expired bread from [DATE] had come from. The Food Service Director stated the toast bread, and sweet rye loaf had come in expired during the most recent bread delivery. They verified that the bagels and marble rye loaf were not dated, and stated the expiration dates for this food was located on the original boxes these bread products were delivered in. The Food Service Director stated that all food items within the kitchen must have an expiration date, and it was important that the kitchen was maintained for the safety of residents and staff. 10NYCRR 415.14(h)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35045 Based on observation, record review, and interview during the recertification and abbreviated (NY00311928) surveys conducted 5/16/2024-5/23/24, the facility did not establish and maintain an infection prevention and 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 8 staff (Certified Nurse Aides #10, #11, #13, #20 and #21; Licensed Practical Nurses #8 and #18, and the Assistant Director of Nursing) observed; and for 1 of 2 residents (Resident #4) reviewed. Specifically, - Licensed Practical Nurse #8 did not perform hand hygiene or wear gloves when administering medication via a gastrostomy tube (feeding tube) to Resident #44 who was on enhanced barrier precautions. - Resident #25 was on contact precautions and Licensed Practical Nurse #8 did not put on the required personal protective equipment prior to entering the resident room and administering insulin; Certified Nurse Aides #10 and #11 entered Resident #25's room and did not put on personal protective equipment prior to providing care; and Certified Nurse Aide #13 entered the resident's room to remove the breakfast food items and did not wear personal protective equipment. - Resident #48 was on enhanced barrier precautions and personal protective equipment was not worn by Certified Nurse Aides #20 and #21, Licensed Practical Nurse #18, and the Assistant Director of Nursing during wound care or incontinence care. - Resident #4's urinary catheter drainage collection bag was lying directly on the floor without a barrier. Findings include: The facility policy, Infection Prevention and Control Program revised 1/2024, documented the Infection Control Program was designed to prevent, identify, report, investigate, and control the spread of infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual arrangement; and to provide a safe, sanitary and comfortable environment; and to help prevent the development and transmission of disease and infection, in accordance with State and Federal Regulations. The facility policy, Enhanced Barrier Precautions revised 3/2024, documented enhanced barrier precautions was an infection control intervention designed to reduce transmission of multidrug-resistant organisms. Enhanced barrier precautions involved gown and glove use during high-contact resident care activities for residents known to be colonized or infected with multidrug-resistant organisms as well as those at increased risk of multidrug-resistant organism acquisition (e.g., residents with wounds or indwelling medical devices). The facility policy, Tube Feedings dated 3/2017, did not address the required personal protective equipment to be used for medication administration. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The undated facility policy, Contact Precautions documented a precaution sign would be placed on the outside of a resident's room door, the isolation cart (contains personal protective equipment) would be placed outside of the resident's door. Gloves would be worn by all staff who entered a resident's room and removed, and hands washed before leaving the area. Gowns would be worn by all staff providing care if their clothes could become soiled with infectious material. 1) Resident #44 had diagnoses including gastrostomy (surgically made opening into the stomach for food). The 3/2/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, required maximum assistance with activities of daily living, and had a feeding tube. The comprehensive care plan initiated on 2/14/2018 documented the resident required a tube feeding as an alternative means of nutritional support for their nutrition and hydration. The 4/23/2024 physician order documented enhanced barrier precautions were to be maintained every shift. During an observation on 5/20/2024 at 10:33 AM, Licensed Practical Nurse #8 prepared medications for Resident #44. They stated the resident received all their medications through the gastrostomy tube. The nurse gathered the required medications and supplies and entered the resident's room. They did not perform hand hygiene or apply gloves. Licensed Practical Nurse #8 reached under the resident's blankets and gown for the gastrostomy tube with ungloved hands and began to prepare for medication administration by administering a water flush. Licensed Practical Nurse #8 stated, Are you marking me down for not wearing gloves? and continued to give the resident medications without wearing gloves. After attempting to give the medications through the gastrostomy tube they stated the tube seemed to be plugged and they were going to get the Unit Manager. They washed their hands in the sink prior to leaving the room. During an interview on 5/20/2024 at 11:11 AM, Licensed Practical Nurse #8 stated they should have worn gloves during the medication administration for Resident #44 to prevent the spread of germs. They thought they washed their hands prior to touching the resident's gastrostomy tube and washed their hands after completing the medication administration and that should have been good enough. During an interview on 5/21/2024 at 8:51 AM, Licensed Practical Nurse Unit Manager #1 stated staff were supposed to wear gloves any time they touched a gastrostomy tube. This was an infection control standard. The staff should have worn gloves upon entering the room. Licensed Practical Nurse #8 should have worn gloves knowing they were going to administer medications and a water flush through a gastrostomy tube. During an interview on 5/22/2024 at 11:30 AM, the Assistant Director of Nursing stated staff should wear gloves when they provided medications through a feeding tube. This was the standard of care. It was important to wear gloves to prevent the spread of pathogens from one resident to another resident. Gloves and hand hygiene were major keys to the prevention of infection in the residents. 2) Resident #25 had diagnoses including asthma, chronic respiratory failure, and diabetes. The 3/13/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required maximum assistance with activities of daily living, and had received insulin in the last 7 days. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5/16/2024 Nurse Practitioner #44 progress note documented the resident's urinalysis (a urine test that checks for infection) and culture (a lab test that checks for bacteria in the urine) was positive for a urinary tract infection. The urine was positive for greater than 100,000 pseudomonades (a type of bacteria). The May 2024 physician orders did not document the resident was to be on contact or enhanced barrier precautions. During an observation on 5/17/2024 at 1:56 PM room had a contact precautions sign on the door. The resident's call light was alarming. Certified Nurse Aide #10 entered the room and did not apply personal protective equipment. They exited the room and stated the resident wanted their juice opened. The resident had stated to them they thought they had the flu. Certified Nurse Aide #10 did not perform hand hygiene. During an observation on 5/17/2024 at 2:13 PM, Resident #25's room had a contact precautions sign posted on the outside of the door. Certified Nurse Aides #10 and #11 started to enter the room not wearing any personal protective equipment or performing hand hygiene. The certified nurse aides paused and read the sign outside the resident's room and continued to walk into the room. There was no personal protective equipment outside of the room. At 2:21 PM, both certified nurse aides exited the room and did not perform hand hygiene. There was a small bottle of hand sanitizer observed outside the door on the railing. The current comprehensive care plan and resident care instructions did not document the resident was to be on contact precautions or enhanced barrier precautions. During an observation and interview on 5/20/2024 at 12:03 PM, there was a contact precautions sign on the resident's door. Licensed Practical Nurse #8 stated they were not sure what the sign was for and thought it was an old sign and proceeded to enter the resident's room to complete a blood sugar via fingerstick. They did not perform hand hygiene and applied gloves. Prior to exiting the room, they entered the bathroom, removed their gloves, and washed their hands. At 12:18 PM, Licensed Practical Nurse #8 prepared the resident's insulin pen, they did not use hand sanitizer or wash their hands, they put on gloves, entered the resident's contact precautions room without all the required personal protective equipment on, and administered the insulin. During an interview on 5/21/2024 at 8:58 AM, Licensed Practical Nurse Unit Manager #1 stated the contact precautions sign was for Resident #25. The resident had a recent urinary tract infection and a fall requiring staples to the forehead. For those two reasons the resident was required to be on contact precautions. Resident #25 had bacteria in their urine and all staff should have known this information. The contact precautions required staff to have full personal protective equipment on when entering the resident's room. Staff were educated on personal protective equipment on 5/17/2024 and the signs on the door instructed the staff on what personal protective equipment to wear. It was important to wear the required personal protective equipment to prevent the spread of germs and to keep the infection confined. Staff should participate in morning report to get updated information on residents and if they had questions, they should be reaching out to them. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2024 at 9:50 AM, Certified Nurse Aide #12 and Certified Nurse Aide #13 stated they were regular staff on Unit 2. Both certified nurse aides stated they were unsure what enhanced precautions meant. Certified Nurse Aide #13 stated Resident #25 was on contact precautions last week. When they entered the room last week not wearing personal protective equipment it was okay because they were just picking up the resident's meal tray. Contact precautions was only needed when providing the resident's personal care. It was important to practice the proper infection control precautions to protect themselves and the residents from germs. During an interview on 5/22/2024 at 11:30 AM, the Assistant Director of Nursing stated if a nurse was performing a fingerstick for a blood glucose check they should be wearing gloves. If Resident #25 was on contact precautions staff should be wearing a gown to protect the resident. When staff did not wear the appropriate personal protective equipment, this was an infection control issue. 3) Resident #48 had diagnoses including urinary incontinence, diabetic foot ulcers, and unspecified skin changes. The 4/28/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent for toileting, bathing, dressing, was always incontinent of bowel and bladder, had diabetic foot ulcers, and had applications of dressings to the feet. The comprehensive care plan initiated 6/12/2023 and revised 4/18/2024 documented the resident had skin breakdown to the left and right heels and open areas to the bilateral buttocks. Interventions included the resident was to be followed by the wound team on weekly rounds, signs and symptoms of infection were to be monitored, and enhanced barrier precautions were to be maintained. Resident #48's physician orders documented: - 12/29/2023 hydrophilic dressing paste that adhered to wet, eroded skin topically, once daily, in a circular motion to open areas on the left and right buttocks. - 4/15/2024 left medial heel diabetic foot ulcer, skin prep to wound base, leave open to air daily. - 4/22/2024 maintain enhanced barrier precautions every shift. - 5/17/2024 zinc cream to coccyx (lower tailbone) twice daily and as needed for prevention of skin alterations. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident #48's incontinence care and wound care on 5/20/2024 at 11:49 AM, Certified Nurse Aide #21 entered the resident's room with a mechanical lift machine (used to transfer residents). Certified Nurse Aide #21 put on gloves and did not perform hand hygiene and did not put on a gown. At 11:55 AM, Certified Nurse Aide #20 entered the resident's room, put on gloves, and did not perform hand hygiene, or put on a gown. They attached the mechanical lift pad to the mechanical lift and transferred the resident from their chair to their bed to perform incontinence care. At 11:59 AM, Licensed Practical Nurse #18 entered the resident's room, put on gloves, did not put on a gown, and did not perform hand hygiene. At 12:01 PM, Licensed Practical Nurse #18 removed their gloves, did not perform hand hygiene, stated they were going to get the Assistant Director of Nursing, and exited the room. At 12:02 PM Licensed Practical Nurse #18 and the Assistant Director of Nursing both entered the room, applied gloves, and did not perform hand hygiene, and did not put on a gown. At 12:06 PM Licensed Practical Nurse #18 applied zinc cream to the resident's buttocks wound wearing gloves. They removed the gloves, washed their hands, and applied new gloves and performed the wound treatment. Hand hygiene was performed by both upon exiting the room. At 12:18 PM, Certified Nurse Aides #20 and #21 transferred the resident back to their medical recliner chair after dressing the resident. Certified Nurse Aides #20 and #21 removed their gloves and exited the room without performing hand hygiene. There was no visible signage near the resident's room that documented the resident was on enhanced barrier precautions. During an interview on 5/20/2024 at 1:07 PM Licensed Practical Nurse #18 stated enhanced barrier precautions were for any resident with a wound, catheter, tube feeding, or history of a super bug (drug resistant bacteria). It was important to protect susceptible residents by wearing a gown and gloves and eye protection if there was a chance of bodily fluid splashes. They should have worn a gown when providing wound care because Resident #48 was on enhanced barrier precautions. There should have been a sign on the door that informed staff of the precautions and what personal protective equipment was needed but it must have fallen off. During an interview on 5/22/2024 at 10:42 AM the Assistant Director of Nursing stated residents who had urinary catheters or wounds were on enhanced barrier precautions. Personal protective equipment was worn with treatment or care such as incontinence care, bathing, or emptying a urinary drainage bag. Resident #48 was on enhanced barrier precautions and they and the other staff members who performed wound care and incontinence care during the observation on 5/20/2024 should have all had at least gowns on. This was important to prevent the spread of infection from one person to another. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2024 at 10:55 AM, the Infection Preventionist stated contact precautions were for residents with infections like clostridium-difficile (an intestinal bacteria), stomach bugs, or urinary tract infections with multiple drug resistant organisms. Staff were required to wear gowns, gloves, masks, and shields when performing care. If a resident had a laceration, abrasion, or a gastrostomy tube feeding they should be on enhanced barrier precautions. Gloves should be worn when performing gastrostomy tube feedings, flushes, or administration of medications for infection prevention control purposes. It was the standard of care to wear gloves for gastrostomy tube feedings, medication administration and flushes. Gloves kept the resident safe. All staff should wear gloves and gowns for enhanced barrier precautions. Whenever a resident was put on precautions, they went to the unit to verify that it was needed. They put an orange dot on the resident's name outside the door and put signage on the back of the door for enhanced precautions. The signs on the front of the door were for contact precautions. During a follow-up interview on 5/22/2024 at 11:30 AM, they stated enhanced barrier precautions were a step above standard precautions to stop the transmission of infections between residents and staff. Gown and gloves were required, and masks were optional and should be used if there was a risk of bodily fluid spray. Residents on enhanced barrier precautions were those that had multi-drug resistant organisms, catheters, gastrostomy tube feedings, open wounds, surgical wounds, or central line devices. Resident #48 was on enhanced barrier precautions for their wounds. Gowns and gloves were required for all the resident's wound care, incontinence care, or any other hands-on care. It was not appropriate that gowns were not worn during wound and incontinence care of Resident #48 because staff could spread infections or give the resident an infection. 10 NYCRR 415.19(a)(b) 48675 49448		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50561 Based on observation, record review, and interview during the recertification survey conducted 5/16/2024-5/23/2024, the facility did not ensure resident call systems were accessible to call for staff assistance for 2 of 2 residents (Residents #15 and #56) reviewed. Specifically, Resident #15 was observed with their call light out of reach, and Resident #56 was left alone in the shower room without access to the call light. Findings include: The facility policy, Call Light, revised 3/2024, documented all residents would have access to and know how to operate the facility call light system to ensure residents' physical and safety needs were met in a timely manner. 1) Resident #15 had diagnoses including amnesia (loss of memory), unspecified pain, and repeated falls. The 3/8/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, severely impaired vision, two falls, and required substantial/maximal assistance for all transfers. The comprehensive care plan dated 9/19/2023 documented Resident #15 was at risk for falls. Interventions included to ensure call light was within easy reach at all times. Resident #15 was observed at the following times: - on 5/16/2024 at 11:49 AM, sitting in their recliner. The call light was resting on the overbed table out of reach of the resident. - on 5/17/2024 at 8:37 AM, resting in bed. The call light was on the floor out of reach of the resident. - on 5/17/2024 at 12:31 PM, sitting in their recliner. The call light cord was clipped to the top right side of the recliner, but the button portion of the cord was laying on the floor out of reach of the resident. - on 5/20/2024 at 8:35 AM, resting in bed. The call light was on the floor out of reach of the resident. At 9:01 AM the resident was in their room and calling, [NAME] Hoo, and Where are you? - on 5/20/2024 at 10:23 AM, sitting in their recliner listening to an audio book. The call light was on the floor out of reach of the resident. (continued on next page)		

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 05/23/2024
NAME OF PROVIDER OR SUPPLIER Jewish Home of Central New York		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at 8:49 AM Certified Nurse Aide #23 stated all call lights needed to be within arm's reach and when a call light was alarming, it had to be answered timely. If a resident could not reach the call light, they would not be able to ask for help, they might try to stand up without assistance, or they could fall and hurt themselves. Call lights should always be within reach even in the bathrooms. Resident #15 did not see well but was able to feel around for things and was able to use the call light effectively. They did not believe the resident had a history of falls or tried to get up unassisted. 2) Resident #56 had diagnoses including left femur fracture (broken thigh bone), dementia, and anxiety. The 2/3/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required maximal assistance for bed mobility, was dependent for transfers and toileting hygiene, was usually understood and could be understood. The comprehensive care plan initiated 6/14/2024 documented the resident had a communication deficit related to a hearing impairment. Interventions included to make certain the call light was within easy reach. During an observation on 5/20/2024 at 11:34 AM, Resident #56 was taken into the shower room and was placed on green plastic mesh shower stretcher. At 12:00 PM, Certified Nurse Aide #27 exited the shower room alone. At 12:12 PM (2 minutes later) Certified Nurse Aide #27 returned to the shower room but the door was locked. They went down the hall to get the nurse and then returned to the shower room door waiting for the nurse. When the nurse arrived 2 minutes later, the key did not work. The nurse went back down the hall to retrieve a different key. When they returned moments later, they were able to unlock the door. The resident was observed lying on their back in the shower stretcher. The shower stretcher was pushed up against the shower stall wall and the call light was at the foot of the stretcher, out of reach of the resident. During an interview on 5/20/24 at 2:00 PM Certified Nurse Aide #27 stated they typically did not leave a resident in the shower room alone but had difficulty getting the help they needed. The nurse was supposed to come to the shower room to perform wound care but did not show up. They were frustrated to be kept waiting, so they left the resident in the shower room while they went to retrieve the nurse. They were unsure how long they had left the resident alone, but stated it was a little while. They described Resident #56 as being stiff, unable to move by themselves, and never attempting to get up by themselves otherwise they would have never left the resident alone. They did not recall if they gave the resident the call light before they left the shower room. They thought about activating the shower room call light to get assistance so they would not have to leave the resident alone but did not think anyone would answer. They stated a resident should not be left alone on a shower stretcher as it could cause anxiety or a fall. During an interview on 5/22/2024 at 8:55 AM Licensed Practical Nurse Unit Manager #1 stated all call lights should be answered within 7-8 minutes and all staff was responsible for answering the call lights. No residents should be left alone without being able to reach their call light. Every resident on the unit should have access to a call light whether they were in their room, in the bathroom, or in the shower room. If call lights were not answered timely residents could fall and get hurt. 10NYCRR 415.29		

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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 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. 27522 Based on record review, observation, and interview during the recertification survey conducted 5/16/2024-5/23/2024, the facility did not maintain an effective pest control program so that the facility was free of pests for 2 of 3 nursing floors (first and second floors). Specifically, there was evidence of drain flies and fruit flies on the first and second floors. Findings include: The Pest Sighting Service Report Log, located in the mail room, documented that no pests were observed by staff from 2/28/2024 to 4/24/2024. The Pest Control Vendor Invoice documented that no pests were observed from 2/28/2024 to 4/24/2024. The Pest Siting Service Report and the Pest Control Vendor Invoice forms did not document the facility areas checked by the vendor. The following observations were made: - on 5/16/2024 at 11:40 AM in the second floor Ridge side spa room, there were 4 live drain flies and multiple dead drain flies. - on 5/17/2024 at 12:15 PM in the second floor kitchenette, there was 1 live fruit fly. - on 5/17/2024 at 12:30 PM in the first floor kitchenette, there were 2 live fruit flies. - on 5/20/2024 at 9:45 AM in the first floor kitchenette, there were 2 live fruit flies. - on 5/20/2024 at 9:59 AM in the second floor kitchenette, there were 2 live fruit flies. During an interview on 5/21/2024 at 11:55 AM, the Director of Environmental Services stated if staff saw pests, they should report it to the housekeeping team lead or a supervisor. They stated the pest control vendor had been doing monthly inspections of the facility for the last three months and no pests had been identified. There were nine drains that were treated to prevent pests and they were not sure if the second floor Ridge spa room drain was included on this list. They stated work orders were entered when staff emailed or called the maintenance department, and all staff should be documenting pests in the mail room pest sighting log. The Director of Environmental Services stated it was important that all areas of facility were checked for pests. During an interview on 5/22/2024 at 9:38 AM, the Food Service Director stated they were not aware of any fruit flies in the first and second floor kitchenettes. They stated the main kitchen utilized a separate pest control vendor from the rest of the facility, and they came monthly. The Food Service Director stated the other vendor checked the rest of the facility for pests. The Food Service Director stated the drains in the facility kitchenettes had a monthly drain treatment done by a vendor, and this treatment could also be completed as needed. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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