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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure proper sanitation and food handling practices to prevent the outbreak of foodborne illness in one (1) of one (1) main kitchen. Specifically, the main kitchen had unlabeled/undated prepared and leftover food; dishes and utensils were not sanitized appropriately; and refrigerators were unclean and in poor repair.Findings include:The facility policy Guidelines for Receiving and Stock Rotation, revised 05/2024, documented food outside its original package would be labeled so staff knew what to use first; and coolers and freezers were checked to ensure all items were dated, labeled, rotated and not expired.The undated facility procedure Sanitizing Food Contact Surfaces documented the sanitizer concentration of the 3-bay sink would be tested at least twice a day for the required concentration.Food Storage During an observation and interview on 03/04/2026 at 10:04 AM, the following was observed in the main kitchen:-two pans of cooked meat in the walk-in cooler were partially covered with plastic wrap and were not labeled or dated. -several prepared food items in the walk-in dairy cooler were not labeled or dated. Food Service Director #40 stated they thought the meat was beef from the day before, the prepared food in the dairy cooler was tuna and egg salad, and the items in the milk cooler might have been ranch dressing. They all should be labeled and dated, and they did not know why they were not. During an observation and interview on 03/06/2026 at 10:30 AM, there were two dented cans on the shelves in dry storage. Food Service Director #40 moved dented cans to an unlabeled shelf in the middle of the room and stated the shelf used to be labeled and they did not know where the sign went. They usually do not have issues with dented cans and kept them on a labeled dented can shelf to return because they could be compromised. Dinnerware Sanitization and Storage During an observation and interview on 03/06/2026 at 10:30 AM, Food Service Worker #41 was washing dishes at the 3-bay sink and demonstrated how they tested the sanitizer strength. They pulled the test strip from the dispenser and placed it in the sanitizer bay, but the strip did not change color to register any sanitizer in the water. They stated there should be a number on the test strip. Food Service Director #40 then tested the sanitizer strength and found the strip did not change color to register any sanitizer in the water. Food Service Worker #41 emptied the sink and refilled the sanitizer bay with hot water instead of the sanitizer solution. Food Service Worker #41 stated this was how they filled the prior sanitizer bay as well. They filled the sink a couple hours prior and washed all the breakfast dishes in the sink. Other food service workers approached the area and removed pans and utensils from the rack of un-sanitized dishes. Food Service Director #40 retrieved the un-sanitized pan and utensils so they could be rewashed. Food Service Director #40 educated Food Service Worker #41 on how to properly fill the sanitizer portion on the sink and instructed them to rewash and sanitize all the dishes again. During an observation and interview on 03/06/2026 at 10:55 AM, Food Service Worker #42 and Food Service Worker #43 were in the dish room running the dish machine. The machine temperature read 158 degrees Fahrenheit for cleaning and 167 degrees Fahrenheit for sanitizing. The dish machine temperatures needed to be greater than 150 degrees Fahrenheit and the sanitizer greater than 180 degrees Fahrenheit. The Food Service Workers kept washing dishes and storing them to dry. Food Service Worker #42 and Food Service Worker #43 stated they did not know what (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the temperatures on the dish machine meant and they were not trained on that information. They stated they sanitized dishes to kill germs. Food Service Worker #42 removed a rack of bowls that were not sanitized at the proper temperature and started to carry them out of the dish room to put them in general circulation. Food Service Director #40 did not intervene until the Department of Health Surveyor stopped the staff member and asked if they should be using items from the rack. During an observation and interview on 03/06/2026 at 11:17 AM, Food Service Worker #41 refilled the 3-bay sink, and the sanitizer bay was rechecked and again tested zero. The water felt ice cold to touch. Food Service Director #40 turned on the dispenser that mixed sanitizer and water, and the water was warm and steamy. The sanitizer tested within appropriate range. The sanitizer sink was refilled, and dishes were re-sanitized. Food Service Worker #41's training records documented they were trained on washing pots and pans. Training included filling the sanitizer bay, testing the sanitizer concentration to make sure it was correct, and making sure the water temperature was at least 110 degrees Fahrenheit. Equipment Safe/Clean During an observation on 03/04/2026 at 10:04 AM, the meat walk-in cooler, dairy walk-in cooler, and milk walk-in cooler had dried food in the gaskets and on the floor. During an observation 03/05/2026 at 9:27 AM, the dairy cooler in the pantry on the first floor was very grimy with dried food debris in unit and the gaskets in poor repair. During an observation and interview on 03/06/2026 at 11:15 AM, the two reach-in refrigerators near the meat cook area had dried food in the gaskets and on the floor in the cooler. Food Service Director #40 stated they usually cleaned them every few weeks. During an interview on 03/09/2026 at 9:33 AM, Food Service Worker #41 stated they worked at the facility for two years and used the 3-bay sink on Fridays. They were trained on its use and usually filled the first bay with the soap and water dispenser, the second bay with warm water, and the third bay with the sanitizer and water dispenser. The water in all three bays should be warm. They were not retrained and got confused because they had not used the 3-bay sink in a couple weeks.During an interview on 03/09/2026 at 9:46 AM, Food Service Director #40 stated all staff were trained when hired, including sanitation and dish machine procedures. The 3-bay sink procedure was to fill the first bay with the soap and water from the pre-mixed dispenser, the second bay with warm water, and the third bay with sanitizer from the pre-mixed dispenser. The staff at the 3-bay sink were responsible for testing the sanitizer strength three times a day using the test strips that hung above the sink and recording the data on a form in the kitchen. Food Service Worker #41 only used the 3-bay sink on Fridays when they were not receiving deliveries and was confused on how to test the concentration of sanitizer because the sanitizing bay sink was not sealing correctly. The Food Service Director was responsible for documenting dish machine temperatures three times a day and they watched to let the staff know if the machine was not reaching proper temperatures. All staff were trained in how to use the dish machine but not reading or recording the machine temperatures. They stated staff should be trained in what the temperatures meant. Staff should not use dishes that were not properly sanitized. They sanitized dishes to kill germs. Cooked meat should be securely covered once cooled, and all food should be labeled and dated. Dented cans should not be used because bacteria could get in the can. 10 New York Codes, Rules and Regulations 415.14(h)

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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. Based on observations, record review, and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for three (3) of eight (8) residents (Residents #79, #68, and #32) reviewed. Specifically, Resident #79 had unclean and untrimmed fingernails and was not assisted with removing unwanted facial hair; Resident #68 was not provided with assistance during meals as planned; and Resident #32 had soiled clothing with food debris. Findings include:The facility policy ADL Care, revised 06/2025, documented each morning and evening, care would be provided according to the resident's level of assistance to include elimination and peri care, partial bathing, mouth care, hair combing, and dressing. Fingernails and toenails were kept clean and at the appropriate length, females would be free from facial hair unless they choose not to have the hair removed, meal set up would be provided by staff and residents would receive assistance with meals as needed, and residents would be provided the opportunity to choose their clothing and if unable, staff would provide choices. 1) Resident #79 had diagnoses including kidney failure and atrial fibrillation (irregular heartbeat). The 02/13/2026 Minimum Data Set (assessment tool) documented the resident was cognitively intact, required partial/moderate assistance with personal hygiene, was dependent for showers and bathing, and did not reject care. The Comprehensive Care Plan initiated 01/29/2026 documented the resident had a focus area in all activities of daily living. Interventions included providing morning and nighttime care and providing grooming and hygiene needs. The undated care instructions documented the resident required partial/moderate assistance with personal hygiene. Resident #79 was observed at the following times: -on 03/04/2026 at 11:48 AM, with multiple patches of white and gray hair on their upper lip, chin, and the top of their neck. Their fingernails were long and had dark brown debris under all five nails on their right hand. The resident stated they did not want hair on their face. -on 03/05/2026 at 3:28 PM, with multiple patches of white and gray hair on their upper lip, chin, and the top of their neck. -on 03/06/2026 at 9:46 AM, with multiple patches of white and gray hair on their upper lip, chin, and the top of their neck. Their fingernails were long and had dark brown debris under all five nails on their right hand. At 10:00 AM, the resident stated they were already cleaned up that morning and staff did not offer to shave them so the hair would just stay on their face. -on 03/09/2026 at 1:49 PM, with multiple patches of white and gray hair on their upper lip, chin, and top of their neck. During an interview on 03/10/2026 at 9:53 AM, Certified Nurse Aide #32 stated they were familiar with Resident #79, and cared for them on 03/04/2026, 03/05/2026, 03/06/2026, 03/09/2026 and 03/10/2026. Resident #32 required total care assistance and never refused care. They noticed the resident's facial hair, but they were very busy during their shifts, so they did not have time to shave (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident. They planned to do it before the end of their shift because it was very noticeable. They were unsure if they were allowed to trim fingernails, but they could clean them. They stated they were not aware the residents had long nails with dark debris underneath. During an interview on 03/10/2026 at 10:54 AM, Licensed Practical Nurse #33 stated personal hygiene consisted of shaving and nail care and was completed daily during every shift by the certified nurse aides. They did not notice Resident #79's facial hair. They thought the resident was diabetic so they were responsible to trim their nails, but the certified nurse aides should keep them clean. During an interview on 03/10/2026 at 11:06 AM, the Assistant Director of Nursing stated personal hygiene consisted of shaving and nail care and was completed daily for every resident by the certified nurse aides. The nurses were responsible for trimming the nails of residents who were diabetic, but nails should always be clean. They were familiar with Resident #79, and they noticed their facial hair a week ago. They spoke with staff at that time and thought they had removed the facial hair. They were not aware the resident had long and dirty fingernails. 2) Resident #68 had diagnoses including dementia and depression. The 01/14/2026 Minimum Data Set (assessment tool) documented the resident had severe cognitive impairment, did not exhibit behavioral symptoms, did not reject care, and required substantial to maximum assistance with eating. The Comprehensive Care Plan updated on 02/18/2026 documented the resident had a focus area in all activities of daily living. Interventions included maximum assistance with eating a mechanically soft diet. The undated care instructions documented the resident required substantial/maximal assistance with eating and was upgraded to a mechanical soft consistency diet on 02/11/2026. During observations on 03/04/2026 Resident #68 was observed sitting at the end of a large oval table, asleep in their chair waiting for lunch on 03/04/2026 at 12:08 PM. At 12:18 PM, they were provided with their meal. No one assisted the resident with their meal, and they remained asleep. At 12:30 PM, Certified Nurse Aide #11 sat down to assist the resident, and at 12:31 PM, they stood up and left the resident. At 12:33 PM, Licensed Practical Nurse #16 sat down to assist the resident. At 12:36 PM, Licensed Practical Nurse #16 stopped assisting Resident #68 and began assisting another resident at the table. At 12:51 PM, Licensed Practical Nurse #16 assisted the resident with their meal again and at 12:58 PM, the resident finished their meal and was removed from the table. During an observation on 03/06/2026 at 12:44 PM, Certified Nurse Aide #31 assisted Resident #68 with their meal and stopped to assist Resident #108. At 12:57 PM, Certified Nurse Aide #31, was not assisting Resident #68 with their meal while sitting next to the resident discussing with other nursing staff who would need to be toileted after lunch. At 1:06 PM, Resident #68 fell asleep and Certified Nurse Aide #31 did not attempt to wake the resident or encourage them to eat and removed the resident from the table. The resident had 50% of their food remaining on their plate, their juice was not opened, and the pureed cherry pie was not touched. During an interview on 03/09/2026 at 8:30 AM, Licensed Practical Nurse #16 stated Resident #68 needed to be assisted with their meal. The resident would say no sometimes, but staff should keep trying. (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 03/10/2026 at 10:08 AM, Certified Nurse Aide #11 stated the resident needed assistance with their meals. There were no assignments for feeding assistance. Staff should sit down and assist a resident. They were not sure if the resident had finger foods and that was why they did not assist them on 03/04/2026 and 03/06/2026 during the noon meal. They stated it was not uncommon to start assisting other residents if the resident said they did not want to eat, but they should continue to encourage them to eat. During an interview on 03/10/2026 at 10:43 AM, Registered Nurse Unit Manager #14 stated if a resident needed assistance any staff in the dining room should assist. Some residents required encouragement and others needed physical assistance. Resident #68 required substantial assistance and needed to be fed. 3) Resident #32 had diagnoses including dementia, depression, and anxiety. The 12/19/2025 Minimum Data Set (assessment tool) documented the resident had severe cognitive impairment, increased in verbal behavioral symptoms directed toward others, did not reject care, and was dependent on staff for most activities of daily living. The Comprehensive Care Plan initiated 11/24/2025, documented the resident had a focus area on activities of daily living and required assistance by staff. Interventions included anticipating the residents' needs for morning and night care. The undated care instructions documented the resident was dependent on staff for dressing the upper and lower body. Resident #32 was observed with soiled clothing, and white and brown substances on the front of their pants and shirt on 03/04/2026 at 10:15 AM and 10:40 AM; and 03/09/2026 at 10:35 AM, and 12:45 PM. During an interview on 03/09/2026 at 1:30 PM, Certified Nurse Aide #11 stated Resident #32 was dependent on staff for care and that included changing their clothing if they were soiled. They were responsible for Resident #32's care and included ensuring the resident's clothing was clean. During an interview on 03/10/2026 at 11:15 AM, Registered Nurse Unit Manager #14 stated Resident #32 was dependent on staff for all personal care. They expected staff assigned to the resident to change their clothing if they were visibly soiled. During an interview on 03/10/2026 at 12:20 PM, the Director of Nursing stated residents should not wear soiled clothing. They expected staff to change the resident's clothing if soiled. 10 New York Codes, Rules and Regulations 415.12(a)(3)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observations, record review, and interviews, the facility failed to ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for two (2) of four (4) residents (Residents #6 and #66) reviewed. Specifically, Resident #6 did not have person-centered interventions in their dementia care plan, and the care plan was not updated to reflect current behavioral symptoms; and Resident #66 did not have interventions included in their dementia care plan regarding their cognitive decline and psychotropic (antipsychotics) medication usage.Findings include: The facility policy Comprehensive Care Plan, revised 05/2024, documented care plans were tailored to the individual needs and preferences of the resident and outlined specific, measurable goals and interventions. Care plans were updated quarterly, annually, and with any change in condition or plan of care. The facility policy Dementia Care, revised 09/17/2025, documented residents were provided with individualized care and services for those with a diagnosis of dementia. Resident behaviors represented an attempt by the person to communicate unmet needs, discomfort, or thoughts that they could not articulate. Care plans consisted of baseline and ongoing details such as frequency, intensity, and duration of common behaviors and specific goals for monitoring interventions for effectiveness. Care plans addressed non-pharmacological approaches for staff to use, which are consistent and focused on the residents' needs. 1) Resident #6 had diagnoses including Alzheimer's Disease and post-traumatic stress disorder. The 01/18/2026 Minimum Data Set admission assessment documented the resident had severe cognitive impairment; had no physical or verbal behaviors; did not reject care; did not wander; felt down, depressed, or hopeless over the last several days; required moderate to maximum assistance with most activities of daily living; and used a walker and wheelchair for mobility. The 01/06/2026 baseline care plan documented the resident had dementia with impaired decision making. Interventions included using simple language, brief statements and offering simple choices. The resident had behavior symptoms and was at risk for aggressive behaviors toward/from staff/others. Interventions included ensure safety and allow time to deescalate when agitated, notify the physician and report behavioral changes, and administer medications as ordered by the physician. There was no documented evidence the care plan was updated or person centered to maximize the residents' dignity and independence. The undated care instructions documented the resident had no behaviors. There were no documented instructions or interventions for staff to use to manage the resident's behaviors related to dementia. The 01/05/2026 at 9:17 AM, Registered Nurse Unit Manager #14 admission progress note documented the resident was admitted from a memory care facility and was oriented to self only. The resident was hearing impaired and had Alzheimer's Disease. The 01/07/2026 at 2:51 PM, Licensed Practical Nurse #16 progress note documented the resident was following other residents in the hallway and into their rooms yelling at them. The resident was (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	redirected. The 01/09/2026 at 8:54 AM, Registered Nurse Unit Manager #14 progress note documented the resident was resistive to care, refused to use the walker, refused nighttime medications, and refused care during the night shift. The 01/09/2026 at 10:03 PM, Registered Nurse Supervisor #39 progress note documented the resident had undressed themself and was naked in the sitting room. The resident would not let staff get them dressed, was yelling out at staff, and was very agitated and aggressive towards staff when approached. The resident continued to yell at staff, ball their fists up at staff, and remained naked. The resident stood up on their own and walked while the staff pulled up the residents' clothing as the resident continued to yell at the staff. The resident was paranoid and convinced staff were poisoning them. The resident did not sleep at all. The 01/29/2026 at 10:31 PM, Licensed Practical Nurse #38 progress note documented the resident was approached for their nighttime medication and spit them out. The resident was approached several times with nursing supervisor assistance and then took medications with ice-cream. The resident continued to walk the unit yelling out can you help? when asked what they needed and continued to yell. The resident refused their night care. The 01/7/2026 Nurse Practitioner #37 progress note documented the resident was seen at request of nursing for follow up on their dementia. They were just admitted from another facility and had a history of dementia with behaviors. The 01/15/2026 Physician #36 progress note documented the resident was seen at request of nursing for concerns of increased agitation, paranoia, and resistance to care. The 01/23/2026 Nurse Practitioner #35 psychiatric evaluation documented the resident was seen for mood changes. The resident had diagnoses of depression, anxiety, post-traumatic stress disorder, and dementia. Staff requested the resident be seen due to concerns of aggression and mood changes. The resident should continue the Valium for anxiety, Lamictal for mood, and Seroquel for agitation and mood lability from dementia, and reinforce coping skills and non-pharmacologic interventions. There were no documented non-pharmacologic interventions or coping skills documented on the care plan. The following observations of Resident #6 were made: -On 03/04/2026 at 11:09 AM, standing near the utility room stating they needed help and was cold, while rubbing their abdomen. An unidentified staff member exited room T19, and the resident reached for their shirt tied around their waist and walked down the hallway toward the nursing station. -On 03/04/2026 from 11:10 AM until 11:36 AM, walking without a walker; telling staff and visitors they were cold, and needed help; trying to take another residents sweater; wandering into the nurses' station and refusing to leave the nurses' station; walking up and down the hallway with a walker, yelling at staff; intruding upon visitors personal space during a musical activity; and telling staff they were cold, and wanted a jacket. Resident #68 appeared to be visibly upset with tears and was difficult for staff to redirect. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/04/2026 at 11:20 AM, an unknown visitor approached the surveyor and stated Resident #6 kept approaching them and saying they were not feeling well. Registered Nurse Unit Manager #14 approached the resident and the resident yelled go away!. Registered Nurse Unit Manager #14 stated let's get some cranberry juice and tried to redirect the resident from the nurses' station with a walker, while the resident shouted, I am freezing!. -On 03/05/2026 at 12:57 PM, seated at a round table alone in front of a television with a plate of food and beverage in front of them. The resident was saying I can't. I need him. and told the surveyor they were having trouble. -On 03/05/2026 at 1:08 PM, the resident approached the surveyor and said they did not know what to do. The resident said their father and mother died and they were afraid. -On 03/06/2026 at 10:36 AM, in a wheelchair wheeling toward the surveyor asking for help and raised their voice and shouted, Could you stop and talk to me?. Certified Nurse Aide #34 encouraged the resident to take deep breaths and offered a drink of soda. During an interview on 03/09/2026 at 1:45 PM, Certified Nurse Aide #11 stated they were not assigned to the resident routinely. They knew the resident required maximal assistance with their personal care, and the resident ambulated independently. They stated they were supposed to look at each resident's care plan prior to the start of their shift. They were told to redirect the resident and just allow the resident to do whatever they wanted. If there were activities, they should try to encourage them to join, and they tried to sit the resident in their recliner. The resident would reach a point when it was difficult to redirect them. They stated they would let the nurse know if the behaviors became too difficult to manage. During an interview on 03/10/2026 at 10:00 AM, Activity Aide #24 stated the activities sometimes got overwhelming because of residents with difficult behaviors, including Resident #6. During an interview on 03/10/2029 at 10:43 AM, Registered Nurse Unit Manager #14 stated that they were responsible for the initial care plan when the resident was admitted . During the interview they reviewed the electronic record and stated they thought Resident #6 had Alzheimer's disease and dementia. They stated the resident was not a regular dementia, they needed a lot of one-to-one interaction and was a very active resident. The resident had episodes of aggressive behavior, and they were afraid the resident would hurt other residents. Resident #6 liked snacks, non-alcoholic beer, and cranberry juice. They agreed the resident care plan was not personalized for their dementia care and they were in the process of updating the comprehensive care plan to be more person centered. They were not aware the comprehensive care plan should be updated with details of the care interventions to manage the residents' dementia. 2) Resident #66 had diagnoses including dementia and major depression disorder with severe psychiatric features. The 01/07/2026 Minimum Data Set assessment documented the resident had severely impaired cognition; did not have behaviors; required maximal assistance/dependent for most activities of daily living and partial/moderate assistance for most transfers; and received antipsychotics, antianxiety, antidepressant, and anticonvulsant medications. The 01/09/2026 Comprehensive Care Plan documented a focus area of cognitive deficits, and the resident exhibited impaired long-term and short-term memory, limited judgement and safety awareness related to dementia. There were no documented interventions. A focus area of (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychotropic drug use. The resident would maintain the highest level of function while receiving the lowest possible dose. There were no interventions documented. The 01/08/2026 Registered Nurse Unit Manager #14 progress note documented the resident was noted to be crying and was observed with negative behaviors, including physical aggression toward nursing staff. The resident was not easily redirected. The 01/14/2026 Licensed Practical Nurse #29 progress note, documented the resident had to be monitored by staff all shift. They were getting up from their wheelchair unassisted and pulling things from tables. Staff attempted to redirect the resident by coloring or reading with no effect. The 02/04/2026 Licensed Practical Nurse #30 progress note documented the resident was unable to be left alone and required constant redirection. Alprazolam (antianxiety) was given at ordered times, but the resident was still restless. The following observations of Resident #66 were made: -On 03/05/2026 at 2:10 PM, in the lounge across from the nurses' station standing between their locked wheelchair and the table, gripping on to the opposite side of the table. -On 03/05/2026 at 2:14 PM, an activities aide brought the resident a puppy activity doll and was actively attempting to interact with the resident and showed them different parts of the doll. The resident took the puppy doll and threw it away from them and sat back down in their wheelchair. -On 03/05/2026 at 2:33 PM, the resident was brought into their room for a nap and was placed in their bed with the blanket pulled up to their chin. A fall mattress was placed beside the bed, and the call bell was clipped to the bed near the right side of the resident's pillow. During an interview on 03/06/2026 at 10:19 AM, Certified Nurse Aide #28 stated care plans were in residents' closets so staff could reference them when needed. Unit managers were responsible for creating and updating care plans. Resident #66 had dementia and at times displayed behaviors. They were unsure if there were interventions in their care plan. There should have been interventions as all residents with dementia should have individualized ways to care for them. During an interview on 03/06/2026 at 10:26 AM, Licensed Practical Nurse #15 stated the nurse manager was responsible for updating care plans. Care plans were supposed to tell staff how to take care of residents and keep them safe. Resident #66 had dementia and was on antipsychotics. Antipsychotic medication was not in the care plan as that was a Health Insurance Portability and Accountability Act violation. They had never seen the resident have behaviors before, so it was not that bad if there were not specific interventions in their care plan. They did not remember if they had seen a dementia care plan for the resident. During an interview on 03/06/2026 at 10:40 AM, Registered Nurse Unit Manager #14 stated residents with dementia or were on antipsychotics should have a care plan. There were psychotropic and dementia care plans, although interventions for dementia care could also be under behaviors. Resident #66 had Alzheimer's dementia with anxiety and depression and was also on antipsychotics. After verification in the resident's electronic medical record, they confirmed there were no interventions documented under psychotropic medication or cognitive impairment and there should be. They stated it was imperative to have a comprehensive care plan for each resident as there were specific ways to (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care for the residents to keep them safe. During an interview on 03/10/2026 at 12:20 PM, the Director of Nursing stated residents with dementia should have care plans specifically tailored to their needs; what triggered them, what made them happy and any other interventions that provided them with the best care. 10 New York Codes, Rules and Regulations 415.12

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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** Based on observations, record review, and interviews the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional standards for two (2) of three (3) medication carts (Terrace Lane and Terrace Ridge); one (1) of two (2) medication rooms (Second floor); and one (1) of two (2) narcotic count sheets (used to reconcile controlled medications). Specifically, the Terrace Lane Medication cart had one (1) unlabeled insulin pen and two (2) bottles of vitamins without expiration dates; the Terrace Ridge Medication cart had had three (3) tubes of unlabeled cream and was unlocked and unsupervised; and the narcotic count sheet for Second floor medication room was illegible. Findings included: The facility policy Drugs and Biological Storage, revised 07/2024, documented all medications and biologicals should be stored securely and properly in accordance with regulatory requirements, manufacturers recommendations, or those of the supplier. Medication carts should be locked when the licensed nurse was away from it or stored in a non-resident area when not being utilized for medication pass.During an observation on [DATE] at 10:09 AM, the Terrace Ridge medication cart was unlocked parked at the nurses' station, with residents walking in and out of the nurses' station. During the Terrace Lane medication cart storage review on [DATE] at 2:04 PM with Licensed Practical Nurse #17, the following was observed in the top drawer of the medication cart:- one (1) opened Lispro (insulin) pen stored in a plastic bag with no opened date and an illegible handwritten name of resident.- two (2) bottles of Prevagen Vitamins with no opened date and no expiration date.Licensed Practical Nurse #17 stated the insulin belonged to Resident #65 and was used. They stated they were able to read the writing, but during observation had placed a printed label on the bag. The Prevagen Vitamins were brought in by families but should have an open and expiration date.The Terrace Lane and Terrace Ridge medication carts were both located within the same nursing station during the observation on [DATE] at 2:04 PM. The Terrace Ridge medication cart was observed to be unlocked and not in use. Licensed Practical Nurse #17 stated this was not their medication cart and the carts should always be locked when not in use, especially on the dementia unit. They stated residents wandered into the nursing station a lot and could get into the medication cart.During the Terrace Ridge medication cart storage review on [DATE] at 2:23 PM, Licensed Practical Nurse #16 stated the medication cart was their responsibility and the cart should not be unlocked, even if the nursing station door was closed. They were not sure why they left the cart unlocked. The unit had a lot of residents who wandered, and they could access the medications in the cart if it was unlocked. There were unlabeled tubes of barrier cream in the drawer. They stated this was used for most residents but not all and should be kept in the treatment cart.During an observation of the Second floor medication room on [DATE] at 3:03 PM, Licensed Practical Nurse #15 confirmed the box of six (6) tubes of barrier cream was a treatment and the cream should be stored in the treatment cart labeled with the resident's name. The narcotic count sheets for each shift medication reconciliation were not legible with medication name and prescription number. Licensed Practical Nurse #15 stated the count sheet was difficult to read.During an interview on [DATE] at 12:20 PM, the Director of Nursing stated they conducted medication cart and medication room audits. The nurses should audit their carts daily. All medications should have a label with the date opened and date expired. The nurses should lock their medication cart when they walked away. The cart should be locked for safety reasons. Narcotic reconciliation sheets should be legible. All staff should be able to clearly read the name and the prescription number to ensure the correct count and to prevent errors.10 New York Codes, Rules and Regulations 415.18(d)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews the facility failed to ensure a clean, comfortable, and homelike environment for one (1) of three (3) resident units (Terrace, Memory care unit). Specifically, the Terrace unit had a strong urine odor, unclean surfaces including stained and sticky floors, and unclean chairs. Findings include:The facility policy Environmental Service, created 09/2024, documented the facility would follow standard cleaning protocols and daily cleaning included: resident rooms, bathrooms, dining areas, nursing stations, common areas, and therapy spaces. Floors were maintained to reduce fall risk and maintain sanitation. Maintenance may include routine mopping, periodic stripping and waxing, carpet vacuuming and shampooing as needed. The facility policy Safe, Clean, Comfortable Homelike Environment, revised 08/2024, documented all staff were responsible for the creation and maintenance of a clean, safe, homelike environment. Regular cleaning and sanitizing of personal and communal living space and equipment was part of a clean environment. The undated facility Daily Room Checklist documented the dining room should be cleaned after lunch, the floors should be swept and mopped in the living areas, and the hallways and quads should be vacuumed as necessary. The following observations were made on the Terrace unit:-on 03/04/2026 at 10:05 AM, there was strong, foul urine odor.-on 03/05/2026 at 9:56 and 1:53 PM, there was strong, foul urine odor.-on 03/06/2026 at 11:18 AM, the dining room area on the Ridge side of the unit smelled of urine.-on 03/09/2026 at 8:14 AM, there was a strong foul urine odor. At 8:59 AM, room T-22, right side, had brown/orange streaks and sticky black spots on the floor, and the entire room smelled of urine. At 10:33 AM and 12:42 PM, two dining room chairs had a red, sticky substance on the side. At 12:44 PM, on Ridge side, a chair in the sitting area was dirty with a brown sticky substance on the back and on the arms. During an interview on 03/04/2026 at 3:25 PM, a family member of a resident stated when they visited their parent the facility had foul odors, and the unit had a strong odor. They stated their parent's room was filthy at times. During an observation and interview on 03/09/2026 at 12:45 PM, Housekeeper #10 stated they were responsible for cleaning the Terrace unit. Cleaning included sweeping, mopping, dusting, and vacuuming the sitting rooms. They were responsible for cleaning the dining room floors and chairs. The dining room chairs and sitting room chairs were cleaned twice a week and as needed. They were not aware of any chairs with sticky red or brown substances. During the interview, Housekeeper #10 observed the chairs with sticky substances and stated they cleaned the chairs, and they would get dirty right away with the residents spilling food. Housekeeper #10 observed room T-22 and stated the floors were stained, they mopped them, but the floors needed to be stripped. They stated they were the only housekeeper on the day shift, and the evening housekeeper was responsible for the dining room floor after dinner, the trash, and the linen. They stated the foul odor of urine was because there were residents that would urinate on the carpeted floor, the carpet was cleaned but it was an old carpet. They were not sure when the carpet was last cleaned. During an interview on 03/09/2026 at 1:51 PM, Certified Nurse Aide #11 stated the unit often smelled of urine, or old food. They stated the resident sitting room chairs may be the source of the odor. They stated if they saw something that required cleaning, they would do what they could and let housekeeping know if a mop was needed to disinfect the area. During an interview on 03/10/2026 at 10:09 AM, Housekeeping Supervisor #12 stated Housekeeper #10 was the full-time housekeeper on the Terrace Unit. There was a housekeeper every day of the week from 7:00 AM- 3:00 PM. The housekeeper had a daily worksheet that was required to be completed during those hours. The resident room floors should be free of stains, and there should not be any dried sticky substances. They were aware of the odors on the unit and stated the Terrace Unit was the only floor that smelled that way. They stated if they shampooed the carpet a resident could urinate on the carpet 20 minutes later. During an interview on 03/10/2026 at 10:43 AM, the Director of Environmental Services stated they had one staff on the Terrace unit on day shift. After 3:00 PM, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was one person for the entire building and one person on the night shift. The day shift housekeeping responsibilities included cleaning/sanitizing bathrooms, shared spaces, resident bathrooms, and the dining rooms. They stated in a perfect world the floors should be free of stains. In February 2026 during the night shift, they shampooed the carpet floor on Terrace. They stated the unit should not have odors and there were things that could be done to rectify the issue. During an interview on 03/10/2026 at 10:43 AM, Registered Nurse Unit Manager #14 stated they were responsible for making notes on environmental issues and reporting these issues to housekeeping and maintenance staff. They stated the unit had an odor, but it was improved. They stated residents urinated on the carpet. They did room audits for cleanliness and let housekeeping know when something did not look clean. They stated they left a voicemail about the floor in room T-22, because it did not look good. New York Codes, Rules, and Regulations Title 10 S415.5(h)(4)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, record review, and interviews during the recertification survey, the facility failed to provide ongoing programs to support each resident in their choice of activities, for one (1) of one (1) Resident (Resident #20) reviewed. Specifically, Resident #20 was not provided with activities, or invited to activities that were of interest and preference.Findings include:The facility policy Activity Policy, last revised 10/2025, documented the activity department would meet the interests and the physical, mental and psychosocial well-being of each resident. All residents shall be encouraged, reminded and assisted to be involved no matter what their level of ability, to all groups centered on their personal preferences, interest and needs based on their comprehensive assessments, care plan and interviews. Resident #20 had diagnoses including dementia, Alzheimer's disease and major depressive disorder. The 06/17/2025 Minimum Data Set (assessment tool) documented the resident had severely impaired cognition, was dependent for all activities of daily living, and activity preferences included listening to music and being around animals such as pets. The Comprehensive Care Plan initiated on 12/13/2021 and updated on 09/13/2024 documented the resident was a long-term care resident and participated in music, enjoyed holding baby dolls or stuffed animals, and liked animal visits. Interventions included the resident would be provided a program calendar to help identify activities of interest. The 02/20/2026, Activities Quarterly Progress note documented the resident was alert and oriented to self only. The resident was pleasant, communicated nonsensical verbally, used body language and facial expression, and was in a wheelchair. They were passive participant in activities. At times they held stuffed animals and baby dolls. Accommodation required for activity would be transportation and cuing/redirecting. They preferred television shows, entertainment/music, social hours and animals.The resident's preferred activity participations documented:-On 12/09/2025 the resident participated in exercise and music.-On 12/17/2025, the resident participated in entertainment.-On 01/23/2026, the resident participated in move to music and an animal visit.-On 02/09/2026, the resident participated in a pet visit.The following observations of Resident #20 were made:-On 03/04/2026 at 2:24 PM, they were seated in a wheelchair around a round table outside of their room. There was another resident seated next to her. There were no activities or interactions being offered. The resident was reaching for their wheelchair breaks, and reaching at the resident seated next to them. There were no staff observed nearby. -On 03/05/2026 at 1:21 PM, they were seated in their chair and reaching for the lift pad underneath them.-On 03/06/2026 at 1:22 PM, they were brought back to the sitting area on the Terrace Ridge side after lunch and there was a music activity starting, music was playing, and other residents began to sit in circle in the area outside of the nursing station. -On 03/09/2026 at 8:20 AM, they were seated in their wheelchair, at the round table outside of their room, pulling at the lift pad underneath them. There were no activities in this area. At 10:36 AM, the resident had fallen asleep in their chair, the television was on across the sitting room, but there was no other activity.During an interview on 03/04/2026 at 3:25 PM, the resident family member stated they did not think the resident participated in any activities at the facility. They stated Resident #20 enjoyed being outside, if the weather was nice; they wished they had pet visits for the resident. During an interview on 03/10/2026 at 9:18 AM, the Director of Activities stated the Terrace unit was a dementia unit, they had musical entertainment, and they had a juke box for playing music. They reviewed the electronic record during the interview and stated the resident enjoyed hand massages, listening to music, pet visits and holding baby dolls. They were not sure how often they involved Resident #20 in the music activities. Any staff person can invite or bring a resident to an activity; it was a team effort but should primarily be activity staff. During an interview on 03/10/2026 at 9:45 AM, activity aide #24 stated Resident #20 liked music activities, and hand massages. They would try to invite them and take them to the music activities. They were not sure why the residents were not invited to the music activities but stated that sometimes the dementia unit residents' behaviors interfered with activities, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and this would get overwhelming. If they were short staffed, they couldn't have a large group of residents for activity, because it would agitate some residents. The resident should have been provided with a busy board or a baby doll if not invited to the music activity.During an interview on 03/10/2026 at 10:00 AM, Certified Nurse Aide #25 stated Resident #20 enjoyed music activities. Any nursing staff member can bring a resident to activities. The resident never refused to go to activities. They have given the resident a baby doll to hold in the past, but it would usually end up on the floor. 10 New York Codes, Rules and Regulations 415.5(f)(1)

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

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

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

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

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

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

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interviews the facility failed to ensure garbage and refuse was disposed of properly for one (1) of one (1) trash compactor. Specifically, there was food debris, food wrappers, milk cartons, used gloves, and dirty utensils, strewn about on the ground surrounding the trash compactor. Findings include: The facility policy Garbage Removal Plan, dated 09/2025, documented garbage bags would be removed to the facility dumpster area from the kitchen when full and at the end of the day and bags would not be overfilled to prevent tearing or spills. Dietary staff would clean garbage containers and surrounding areas, and dietary managers would monitor compliance with garbage disposal procedures. During an observation on 03/06/2026 at 08:14 AM, there was food debris, food wrappers, milk cartons, used gloves, and dirty utensils strewn about on the ground near the food compacter area. During an interview on 03/06/2026 at 11:45 PM, Food Service Director #40 stated the area near the trash compacter had food and debris because of all the snow and from plowing. They stated there should not be debris on the ground because it attracted pests. 10 New York Codes, Rules, and Regulations 415.14(h)