

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Central Park Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 116 East Castle Street Syracuse, NY 13205	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than two hours after the allegation was made for one (1) of three (3) residents (Resident #1). Specifically, on 05/16/2026 during the 7:00 AM to 3:00 PM shift, Licensed Practical Nurse #3 alleged they witnessed Certified Nurse Aide #15 to have been verbally abusive and pushed Resident #1 toward a dining room chair. The incident was not reported as required and Certified Nurse Aide #15 continued to have access to residents. On 05/20/2026, the Director of Nursing discovered a written statement in their mailbox from Licensed Practical Nurse #3 that described the incident on 05/16/2026. Resident #1 was not assessed until 05/18/2026 at approximately 8:30 AM. Findings include: The 04/2026 revised facility policy, Abuse Prevention, documented in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must ensure that all alleged violations involving abuse, neglect or mistreatment, including injuries of unknown source or misappropriation of resident property, are reported immediately, but not more than two hours after the allegation is made if the events that cause the allegation involve abuse. Resident #1 had diagnoses of Alzheimer's Disease and Unspecified dementia, severe with agitation. The 02/24/2026 Minimum Data Set assessment documented Resident #1 had severely impaired cognition, wandered daily, had no behaviors, and no rejection of care. The Comprehensive Care Plan reviewed 03/03/2026 documented the resident had potential for behavior problems, socially inappropriate behaviors related to Alzheimer's Disease, new environment, and new routines. Interventions included: reapproach, medications as ordered, wander alert device, redirection, provide safe quiet environment, approach in calm, positive manner, allow to express in appropriate ways, observe for signs of intent to harm self or others, divert attention, take to another location, assist with clothing when seen removing, and 1:1 supervision every day and evening shift (02/17/2026). The 05/17/2026 at 2:23 AM nursing progress note by Licensed Practical Nurse #21 documented Resident #1 was self-ambulating on the unit, as needed Ativan (an anti-anxiety medication) given with zero changes noted, and was difficult to redirect. No pain noted. The 05/17/2026 at 7:02 AM nursing progress note by Registered Nurse Supervisor #11 documented Resident #1 had not slept throughout the night. The resident was ambulating around the unit, and they were difficult to redirect. As needed medication given with no effect. Resident #1 pulled the fire alarm on the unit, which necessitated a 1:1 supervision for the remainder of the shift as attempts to redirect the resident were unsuccessful. The attending physician was notified for a requested medication review and medical will follow-up. Nursing will continue to monitor. The resident has no pain. The 05/18/2026 at 3:00 AM nursing progress note documented Resident #1 was in bed resting, 1:1 supervision continued, zero changes noted this shift, and the resident did not have pain. The 05/18/2026 at 9:45 AM nursing progress note by Registered Nurse Supervisor #10 documented a bruise was noted on Resident #1's left inner buttock to their left hip. There was no swelling or signs/symptoms of pain and is unaware of how area occurred. Per documentation, the resident had episodes of increased agitation and behaviors over the weekend. The resident has a history of poor safety awareness related to poor cognition. Nurse Practitioner #13 was made aware, the resident was assessed, and no new orders were provided at this time. The resident's (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
--	-------	-----------

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Central Park Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 116 East Castle Street Syracuse, NY 13205	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative was updated and the resident continues on 1:1 monitoring at this time. Resident #1 appears to be calm and cooperative currently. The 05/18/2026 at 8:30 AM Accident/Incident report completed by Licensed Practical Nurse Manager #7 documented Licensed Practical Nurse #16 reported Resident #1 had a bruise on their left buttock and left hip, was dark purple in color and measured 36 centimeters x 12 centimeters. Staff were interviewed and witness statements were obtained. The 05/18/2026 Facility Investigation Summary documented on the morning of 05/18/2026, the Director of Nursing found a written statement from Licensed Practical Nurse #3 dated 05/16/2026. The statement alleged abuse by Certified Nurse Aide #15 toward Resident #1. The Director of Nursing was not notified of the allegation at the time. Immediate action was taken to investigate; Certified Nurse Aide #15 was placed on administrative leave, and an investigation was started. The facility investigation summary documented abuse allegations could not be verified based on staff interviews, no witnesses, and Licensed Practical Nurse #3 recanted their allegations in a second statement. The Director of Nursing did not find a correlation between the allegation involving Certified Nurse Aide #15 and Resident #1's bruise. There was no documented evidence the alleged witnessed incident that occurred on 05/16/2026 during the 7:00 AM to 3:00 PM shift was reported to a Nursing Supervisor or Administrator immediately following the alleged incident. During an interview on 05/28/2026 at 1:57 PM, Licensed Practical Nurse #3 stated they wrote a statement on 05/16/2026 stating that Certified Nurse Aide #15 yelled at Resident #1 and handled them roughly by redirecting them to have a seat into a dining room chair. They stated they reprimanded Certified Nurse Aide #15 for cursing around the residents and family members. Certified Nurse Aide #15 became 'mouthy' after they were reprimanded. Licensed Practical Nurse #3 wrote them up and placed the paperwork into the Director of Nursing's mailbox. During a follow-up interview on 05/29/2026 at 10:18 AM, Licensed Practical Nurse #3 stated they wrote a second statement regarding the incident on 05/16/2026 and recanted what they initially documented. They stated they misinterpreted what they witnessed with Certified Nurse Aide #15, it was not abuse, they were both angry with each other and 'worked up' and felt it was just a personal issue. Licensed Practical Nurse #3 stated they did not report the incident to a Supervisor, the Director of Nursing or the Administrator. They wrote up Certified Nurse Aide #15 for cursing and placed the paperwork in the Director of Nursing's mailbox prior to leaving the facility. They did not learn Resident #1 had a bruise until 05/18/2026. During an interview on 05/29/2026 at 12:30 PM, the Director of Nursing stated they were not aware of an incident with Certified Nurse Aide #15 and Resident #1 until the morning of 05/18/2026 when they received a written statement from Licensed Practical Nurse #3 in their mailbox. They immediately started an investigation. Certified Nurse Aide #15 was placed on administrative leave. The Director of Nursing spoke to Licensed Practical Nurse #3 about the allegation and questioned the reason for not reporting it on 05/16/2026. Licensed Practical Nurse #3 stated it was not abuse, they felt the aide was angry for being reprimanded and their statement was not accurate due to the licensed practical nurse being frustrated with Certified Nurse Aide #15 at the time. The Director of Nursing asked Licensed Practical Nurse #3 to demonstrate how the Certified Nurse Aide #15 guided Resident #15 to sit. Licensed Practical Nurse #3 stated it was not forceful and could not have contributed to the bruise on the resident's buttock/hip area. Staff who cared for the resident 05/16/2026-05/17/2026 reported there were no signs of bruising. The area was first noticed on the morning of 05/18/2026. The Director of Nursing stated Licensed Practical Nurse #3 should have notified a supervisor of any suspicion of abuse based on their initial statement. Staff had educational training on Abuse prevention and reporting and were expected to notify a Supervisor, Director of Nursing, and Administrator. During an interview on 06/01/2026 at 1:32 PM with the Administrator, they stated they were not aware of the allegation related to Certified Nurse Aide #15 and Resident #1 until the morning of 05/18/2026. They expected all staff to report any suspicions of abuse, and their priority was to keep the residents safe. Staff had multiple training sessions throughout the year on abuse prevention and reporting. It was not facility protocol to leave a notice (of an abuse allegation) in the mailboxes. New York Codes, Rules and Regulations 415.4 (b)(2)(3).		