STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335283	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Camillus Residential Health Care Facility	813 Fay Road Syracuse, NY 13219

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews during the recertification survey (complaint #2643650) the facility failed to treat each resident with respect and dignity and in a manner and environment that promotes maintenance or enhancement of quality of life, recognizing each resident's individuality. Specifically, during a confidential group meeting thirteen (13) of thirteen (13) residents stated they experienced long call bell response times and multiple observations were made of long call bell response times.Findings include:The facility policy Resident Rights, last reviewed 5/14/2024, documented residents had a right to a dignified existence, self-determination, communication with and access to persons and services both inside and outside of the facility. The facility policy Meeting Resident Needs, revised 12/20/2023, documented the nursing staff response to resident needs (including call bells) was expected to occur regardless of credential, title or resident assignment; response to resident needs should take priority over other routine tasks; licensed nursing staff would monitor unit response to call lights and direct staff as needed to ensure that resident needs were met; and when a resident activated their call bell, or verbally requested assistance, response should be within 10-15 minutes. The following call bell wait times were observed on the call bell monitor located at the nurses' station: -On 01/05/2026 at 9:39 AM, Resident #105's call bell light was on for 70 minutes; -On 01/05/2026 at 9:39 AM, Resident #123's call bell light was on for 39 minutes; -On 01/06/2026 at 3:21 PM, Resident #123's call bell light was on for 36 minutes; and -On 01/08/2026 at 8:28 AM, Resident #18's call bell light was on for on 40 minutes. The following observations and interviews regarding Resident #102's call bell were made on 01/07/2026: -at 10:10 AM, the call bell monitor located at the nurses' station documented the call bell was on for 70 minutes. Certified Nurse Aide #7 entered the room briefly, turned off the call bell and exited the room. Certified Nurse Aide #7 stated they answered Resident #102's call bell and the resident wanted their table moved and to get up. They were going to report it to the aide that was assigned to the resident. -at 10:12 AM, Resident #102 was lying in bed. They stated they thought their light had been on for (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 - Some	about an hour and needed to go to the bathroom. The aide who just answered the bell said they would get their aide to come help them. -at 10:20 AM, the call bell light was back on. -at 10:29 AM, Medical Secretary #9 entered Resident #102's room, turned off the call bell light, and exited the room. Resident #102 was in bed and stated the aide that was just in said they had to go get their aide, which meant they were going to have to put their light back on. -At 10:32 AM, the call bell light was back on. -At 10:42 AM, the call bell light was off, and staff were in the room assisting the resident to the bathroom. During a follow up interview on 01/07/2026 at 2:20 PM, Certified Nurse Aide #7 stated all aides were responsible for call bells and they should be answered within 10-15 minutes. If they answered a call bell for someone not on their assignment and they needed something easy they would meet that need. If that resident was requesting care or their shower, they would not have time to provide that due to having their own assignment, but they would let the resident's assigned aide know. If someone requested to be toileted, they helped with that as they would not want a resident to be incontinent. They were unaware how long Resident #102's call light was on. They did not have time to help the resident get up as they had to give a shower to another resident. During an interview on 01/08/2026 at 8:57 AM, Medical Secretary #9 stated when answering a call light, they turned the call bell light off if they could not fulfill the resident's need, and the find the person who could. Answering call bells was everyone's responsibility and the goal was to answer them within 5-10 minutes. During an interview on 01/08/2026 at 9:34 AM, Licensed Practical Nurse Manager #10 stated call bells should not go unanswered for more than 10 minutes and anything over 30 minutes was excessive. Anyone could answer a call bell and if the need could not be met it should be reported to whomever could meet that need. During an interview on 01/09/2026 at 10:56 AM, Registered Nurse Clinical Coordinator #8 stated they expected call bells to be answered within 15 minutes. Everyone could answer call bells and if a resident was requesting to use the bathroom they should be taken, even if that resident was not assigned to the person answering the bell. They checked the call bell monitor and noticed long wait times in the past. They stated a 40 and 70 minute call bell wait time was excessive. No one should wait that long. 10NYCRR 415.3 (c)(1)(i)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review during the recertification survey (complaint #652367) the facility failed to ensure the interdisciplinary team determined a resident's ability to safely administer their own mediations, if clinically appropriate, for two (2) of three (3) residents (Residents #108 and #260) reviewed. Specifically, Resident #108 had a prescribed nasal spray on their bedside table and Resident #260 had unprescribed elderberry supplements on their bedside table. There was no documented evidence of assessments and/or physician orders for the residents to safely self-administer medications.Findings included:The facility policy Self Medication, revised 06/18/2008, documented the procedure for self-administer of medications included identifying the resident who may be appropriate for self-medication, a physician order was obtained, and a resident self-medication administration record was completed. A self-medication pill holder that the resident was comfortable with was sent to pharmacy and filled with one week's worth of medication. The pill holder was kept in the medication cart or in the resident's locked drawer. 1) Resident #108 had diagnoses including acute and chronic respiratory failure and aspergillosis (a fungal lung infection caused by inhaling certain mold spores). The 12/24/2025 Minimum Data Set assessment documented the resident had intact cognition and required set-up to moderate assistance for most activities of daily living. The 12/17/2025 physician order documented ipratropium bromide nasal solution 0.03% (blocks mucous production) sprayed twice in both nostrils four times a day for allergies. During observations on 01/05/2026 and 01/07/2026 ipratropium bromide nasal spray was on the resident's overbed table without licensed staff present. There was no documented evidence of a provider order for self-medication administration or a self-medication administration assessment. The 01/07/2026 Medication Administration Record documented ipratropium bromide nasal solution, two (2) sprays in both nostrils four times a day at 9:00 AM, 12:00 PM, 5:00 PM, and 8:00 PM. Licensed Practical Nurse #3 documented they administered Resident #108's ipratropium bromide nasal spray at 9:00 AM. During an interview and observation on 01/07/2026 at 11:01 AM, Licensed Practical Nurse #3 stated residents administered their own medication after an assessment and a provider order was obtained. Medications should not be at the bedside if the resident did not have an order or assessment. They confirmed the nasal spray was on Resident #108's overbed table. They stated they did not get an order for the resident to self-administer medication, but they should have. The nasal spray should not have been on the resident's overbed table. During an interview on 01/07/2026 at 11:08 AM, Registered Nurse Unit Manager #4 stated residents should not have medications at their bedside until they were assessed for appropriateness, and a provider order was entered. Resident #108 did not have an order for self-medication administration. The resident should not have the nasal spray at the bedside as it was a medication. Nasal spray should be kept in the locked medication cart. 2) Resident #260 had diagnoses including heart disease and syncope (temporary loss of consciousness) and collapse. The 12/15/2025 Minimum Data Set assessment documented the resident had moderate (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitive impairment, one-sided upper extremity mobility impairment and required set-up/clean-up assistance for most activities of daily living. The discontinued physician order documented elderberry zinc/vitamin C/immune mouth/throat lozenge, place and dissolve one tablet buccally (cheek) one time a day for supplement was discontinued on 03/04/2025. The 03/21/2025 Nurse Practitioner #6 progress note documented due to polypharmacy (use of multiple medications), vitamin C, vitamin D, vitamin B-12, triamcinolone, and elderberry tablets were discontinued. Elderberry supplement was observed on Resident #260's bedside table on 01/05/2026 at 9:48 AM and 01/06/2026 at 8:58 AM. There was no documented evidence of a physician order for elderberry supplements. There was no documented evidence of a physician order for self-medication administration or a comprehensive care plan for the ability to self-administer medications. During an interview and observation on 01/07/2026 at 10:18 AM, Licensed Practical Nurse #5 stated Resident #260 was not taking any supplements, including elderberry supplements. The resident did not have orders to self-administer any medications. Licensed Practical Nurse #5 confirmed Resident #260 had elderberry supplements on their bedside table. The resident should not possess medications that were not ordered. They stated they did not notice the supplements at the bedside. During an interview on 01/07/2026 at 10:25 AM, Resident #260 stated they have taken the elderberry supplements every day since they were admitted . Their child brought the supplements into them. During an interview on 01/07/2026 at 10:48 AM, the Director of Nursing stated residents should not have medications at the bedside. They could only have them if there was a provider order and they proved they could take them safely. Elderberry supplements and nasal spray were medications and therefore should not have been at the residents' bedside without the provider order and an assessment. It was a huge safety issue for medications to be left at the bedside. 10 NYCRR 415.3(f)(1)(vi)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews during the recertification and abbreviated survey (2643650) the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for one (1) of four (3) residents (Resident #17) reviewed. Specifically, Resident #17 had brown debris underneath long, untrimmed fingernails; had foul breath; was unshaven; and did not receive their shower as plannedFindings include: The facility policy Activities of Daily Living (ADLs) Supporting, effective 12/22/2023, documented residents were provided with the necessary services to maintain good grooming, nutrition, personal, and oral hygiene when the resident was unable to carry out activities of daily living. Hygiene included bathing, dressing, grooming, oral care, mobility, toileting, communication, eating, and drinking. The facility policy Shaving, effective 12/29/2023, documented nursing facility would ensure a resident who was unable to carry out required grooming received the necessary services to maintain good grooming, including the management of facial hair for both men and women. The facility policy Oral Care, effective 12/29/2023 documented nursing facility would ensure that a resident who was unable to carry out required oral care received the necessary services to maintain good oral hygiene. The facility policy Grooming Fingernails, revised 12/21/2023, documented residents who required assistance with fingernail grooming would be provided with the necessary staff assistance to maintain fingernails in a clean and neat appearance consistent with resident preferences. Resident #17 had diagnoses including kidney disease and and diabetes. The 12/18/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not exhibit behavioral symptoms, did not reject care, required partial/moderate assistance for oral care, and was dependent for most activities of daily living. The Comprehensive Care Plan initiated 9/22/2025, documented the resident had a deficit in activities of daily living related to muscle weakness and immobility. Interventions included supervision for oral care and partial/moderate assistance of one for bathing and dressing. The undated Resident Profile (care instructions) documented the resident transferred with a mechanical lift; was dependent on two for toileting, dependent for personal hygiene, and required supervision with oral hygiene, and bathing/showers. Their shower day was on Tuesday during the 7:00 AM-3:00 PM shift. The certified nurse aide shower task documented not applicable on 12/23/2025 and 12/30/2025. Resident #17 was observed with jagged fingernails and brown debris behind and around their fingernails, bad breath, and was unshaven on 01/05/2026 at 10:29 AM; 01/06/2026 at 2:10 PM; and 01/07/2026 at 9:49 AM During an interview on 01/07/2025 at 9:49 AM Resident #17 stated they were not sure what day their shower was. They never refused their shower and did not remember the last time they had a shower. They wanted their hair washed and combed, their nails cleaned and cut, their teeth brushed, and to be shaved. They especially wanted a shave as they were always clean shaven. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/07/2026 at 10:05 AM, Certified Nurse Aide #23 stated they were responsible for providing hygiene care for residents on shower days and as needed. Showers were provided weekly with hygiene care. On shower days care included washing the resident, washing hair, brushing teeth, and clipping nails. On other days, the residents were provided a bed bath which included washing the body and the groin area, combing hair, brushing teeth, and providing nail care. Nails should be cut and cleaned even if it was not their shower day. Oral care should be completed twice a day to prevent heath issues and residents shaved for dignity reasons. Resident #17 was scheduled for their shower on 01/06/2026. The resident did not receive a shower that day because they required a mechanical lift to get into the shower and staffing was limited, so they gave the resident a bath in bed. They did not notice the resident's nails that morning and should have. They did not shampoo the resident's hair because the resident did not get a shower. They did not provide oral care, nail care, or shave the resident because they were busy. During an interview on 01/09/2025 at 12:09 PM, Assistant Director of Nursing stated they expected the scheduled shift to complete the resident's weekly shower. Showers were completed by the certified nurse aides, however, licensed practical nurses could assist. If a resident refused a shower, the assigned certified nurse aide should notify the charge nurse or team lead. The charge nurse or team lead should approach the resident and if the resident still refused document a progress note and pass on to the next shift. The next shift or next day the shower was offered again. At times care was not completed, including showers, because of short staffing. 10 NYCRR 415.12(a)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews during the recertification survey (complaint #652393) the facility failed to ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety for one (1) of one (1) main kitchen. Specifically, in the main kitchen food in the cooler was not labelled, expired food was not discarded, the dish machine was not functioning properly while in use, and food service equipment was unclean. Findings include:The facility policy Food Safety and Procurement, last reviewed 03/2025, documented food would be discarded based on food labels or upon evidence of spoilage. Food which was not properly labeled and dated was discarded. Food service staff would monitor the refrigerators daily and discard outdated food. Strategies to control food borne illness included equipment and utensil cleaning and sanitizing, including the dish machine.The facility procedure Daily Cleaning Assignments, last reviewed 02/2020, documented the refrigerators and ovens would be cleaned daily.The facility procedure Weekly Cleaning Assignments, last reviewed 02/2020, documented the ovens would be deep cleaned weekly.The facility policy Cleaning Schedules, last reviewed 02/2020, documented any food spills in the oven would be cleaned up immediately and ovens would be cleaned daily or biweekly as needed. Refrigerator food spills would be cleaned up daily.The following observations were made in the main kitchen:- on 01/05/2026 at 9:32 AM a bag of meat, cheese slices, a white bag of food, and a meat salad were not labelled in the upstairs walk-in cooler, preparation refrigerator, and salad refrigerator. The upstairs walk-in cooler contained expired food including two large containers of sour cream with an expiration date of 11/30/2025, and two cases of milk with an expiration date of 01/02/2026.The sandwich cooler, preparation cooler, and salad cooler had accumulated debris and residue.-on 01/07/2026 At 9:30 AM, the ovens had dried on, burnt food spillage on the bottom. At 9:45 AM, staff were washing breakfast dishes while the dish machine was not functioning properly. The dish machine temperature was checked or recorded for the day, and the temperature dial did not move above 120 degrees Fahrenheit during the wash and sanitation cycles.During an interview on 01/07/2026 at 9:45 AM, Executive Chef #12 stated the dish machine temperature was taken daily at 11:00 AM. They stated dishes should not be used if the dish machine was not cleaning or sanitizing at the required temperature.During an interview on 01/07/2026 at 9:50 AM, Food Service Director #13 stated dishes should not be used if the dish machine was not cleaning or sanitizing at the required temperature because they are not sanitized to kill germs.During an interview on 1/8/2025 at 11:56 AM, Food Service Team Lead #11 stated they usually recorded the dish machine temperature daily after the machine warmed up, around 9:45 AM. They were running late that morning and forgot. During an interview on 01/08/2026 at 12:08 PM, Food Service Director #13 stated Team Lead #11 recorded the temperatures in the morning after warming the dish machine up and the missing temperature check yesterday was an oversight. Food in the coolers were rotated based on the first in first out method and all staff were trained in this method. The refrigerators and ovens were cleaned based on the cleaning schedule. All food should be labelled and dated once they were removed from the original case. During an interview on 01/08/2026 at 2:38 PM, Licensed Practical Nurse #15 stated they found outdated and spoiled milk in the unit refrigerator in the past but discarded it without serving it. 10 NYCRR 415.14(h)