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

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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 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 about an hour and needed to go to the bathroom. The aide who just answered the bell said they would (continued on next page)

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	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 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. Based on observations and interviews, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for four (4) of seven (7) medication carts (Unit 2 East and West, Unit C, and Unit D) and one (1) of three (3) medication rooms (Unit 2) reviewed. Specifically, the Unit 2 [NAME] cart had insulin pens that were not labeled with the open or expiration dates, and expired medications; the Unit 2 East cart had insulin pens that were not labeled with open or expiration dates; the Unit C cart had insulin pens, nasal sprays, and inhalers not labeled with open or expiration dates and expired medications were left in the cart; the Unit D cart had insulin pens and inhalers that were not labeled with open or expiration dates; and the Unit 2 medication room had supplies directly on the floor under the sink.Findings included:The facility policy Medication Administration, revised 06/20/2019, documented all multidose vials/containers were labeled with the facility provided medication sticker and included the expiration date, which was 28 days from the open date. Licensed nurses checked the expiration dates prior to administration of any multidose vial containers to ensure the medication was not expired; if expired the medication was discarded immediately. The facility policy Insulin Administration, revised 01/02/2020, documented the licensed nurse checked the expiration date of insulin pens prior to administration. During an observation and interview with Licensed Practical Nurse #24 on 01/07/2026 at 1:29 PM, the top drawer of the Unit 2 [NAME] medication cart had two lispro insulin pens and one Lantus insulin pen without an open date or expiration date on the label. Licensed Practical Nurse #24 stated insulin pens were labeled when opened and expired in 28 days. They were not sure why they were not labeled as they were given on the evening shift. Whoever opened the insulin pen was responsible for labeling the pen. If they saw insulin or any medication that was expired or not labeled, they discarded it and notified the unit manager. There was a vitamin C container that expired in 12/2024. Licensed Practical Nurse #24 stated no one was on vitamin C and was not sure why it was still in the cart. Every nurse was responsible for making sure medications were discarded when expired. During a follow-up observation and interview with Licensed Practical Nurse #24 on 01/07/2026 at 2:08 PM, in the Unit 2 medication room there was a box and bag stored on the floor under the sink. Licensed Practical Nurse #24 stated they had agency nurses that did not know things could not be kept on the floor. During an observation and interview with Licensed Practical Nurse #36 on 01/08/2026 at 9:35 AM, the top drawer of the Unit 2 East cart had Lantus insulin pen that was not labeled with the open or expiration date. Licensed Practical Nurse #36 stated all insulins were labeled with open date as they were not as effective after 28 days. They were not sure why it was not labeled. The second drawer had a budesonide inhaler that was opened on 11/18/2025. Licensed Practical Nurse #36 stated they were not sure if inhalers needed to be labeled when opened or when they expired. They administered the inhaler to the resident that day as they did not think that inhalers expired and were used until they were gone. During an observation and interview with Licensed Practical Nurse #52 on 01/08/2026 at 10:23 AM, the first drawer of the Unit D cart had eye drops that expired 01/2022, a Lantus insulin pen and a lispro insulin pen were not labeled with the open or expiration date. Licensed Practical Nurse #52 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the eye drops should not have been in the cart and was unsure why they were. They must have been overlooked the last time they looked through the cart. Insulin pens should be labeled with an open date and the expiration date; they were only good for 30 days after they were opened and then were thrown out. They stated they must have been too busy when they opened the insulin pens and forgot. They were sure they would have noticed when they gave the insulin to the resident. The third drawer of the cart had a Trelegy Ellipta inhaler that was not labeled with the open or expiration date. Licensed Practical Nurse #52 confirmed the packaging of the inhaler stated to discard six weeks after open date. They did not write the open date on the inhaler because there were only 30 doses, and it would be discarded all the doses were gone. During an observation and interview with Licensed Practical Nurse #30 on 01/08/2026 at 2:53 PM, the first drawer of the Unit C cart had two lispro insulin pens that were labeled with the open date or expiration date. Licensed Practical Nurse #30 stated insulin pens were only good for 28 days after they were opened. They should have been dated, but they were like that when they started their shift. The first drawer also had four nasal sprays that were not labeled with an open date or expiration date. Licensed Practical Nurse #30 stated nasal sprays were only good for 28 days. However, they never dated them and always went by the date the medication was ordered as the opened date. Additionally, in the first drawer of the cart there were atropine 1% eye drops that were opened on 09/12/2025 and expired 10/01/2025. Licensed Practical Nurse #30 stated that the resident no longer took eye drops and they should have been discarded as they were old. In the second drawer of the cart there were two Trelegy Ellipta inhalers and one Incruse Ellipta inhaler that were not labeled with an open date or expiration date. Licensed Practical Nurse #30 stated they never labeled when the medication was opened, they went by how many doses were left in the inhaler and discarded when it was empty. During an interview on 01/09/2026 at 12:09 PM, Assistant Director of Nursing #37 stated insulin should be labeled because it expired 28 days after it was opened. It should not be administered if it was expired or not labeled with the open date. Licensed practical nurses checked their carts before their shift and after, so it was ready for the next shift. The carts were checked daily. If there was an outdated medication it needed to be discarded. 10NYCRR 415.18(d)

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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)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews during the recertification survey, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (2) of ten (10) staff (Certified Nurse Aide #35 and Environmental Services Worker #48) reviewed for influenza vaccinations; and five (5) of eight (8) residents (Residents #66, #87, #195, #244, and #268) reviewed for transmission based precautions. Specifically, Certified Nurse Aide #35 and Environmental Services Worker #48 declined the influenza vaccine and were observed wearing their masks below their nose while in resident areas; and Resident's #66, #87, #195, #244, and #268 were on droplet precautions for diagnoses of influenza and/or COVID-19 and staff were observed not wearing appropriate personal protective equipment when entering their rooms.Findings include:InfluenzaThe facility policy Staff influenza Vaccination, policy, revised 12/16/2022, documented influenza immunization would be offered to all staff when it becomes available each season annually, unless the immunization is medically contraindicated, or the individual has already been immunized during this time. Staff who declined to receive the vaccination with no medical contraindication must execute a signed declination of influenza vaccination and be compliant with wearing a mask during flu season.Influenza records were requested for 10 random staff and received on 01/08/2026.Environmental Services Worker #48 signed the facility's declination for the influenza vaccine on 12/12/2025.Certified Nurse Aide #35 signed the facility's declination for the influenza vaccine on 12/15/2025.During an observation on 01/05/2026 at 12:28 PM, Certified Nurse Aide #35 was walking in the hallway on the 2nd floor with their mask below her nose.During an observation on 01/06/2026 at 2:06 PM, Environmental Services Worker #48 was observed walking through the C-Unit with their mask below their nose.During an observation on 01/07/2026 at 10:37 AM, Certified Nurse Aide #35 was observed at the nurse's station with their mask below their nose talking to a resident. During an interview on 01/08/2026 at 11:14 AM, Certified Nurse Aide #35 stated they declined their influenza vaccine and was supposed to wear a mask while working. They stated the mask frequently slipped down and they were supposed to wear the mask to help prevent the spread of germs.During an observation on 01/09/2026 at 09:03 AM, Certified Nurse Aide #35 was observed walking through the 2nd floor dining room with their mask below their nose, there were 11 residents seated in the dining room. When Certified Nurse Aide #35 saw the surveyor, they pulled their mask above their nose.During an interview with Registered Nurse/ Infection Preventionist #37 on 01/09/2026 at 12:09 PM, they stated they observed Certified Nurse Aide #35 not wearing their mask appropriately and needed to tell them to put it on correctly all the time. If staff declined the influenza vaccine, they should wear a mask while working to prevent the spread of infection.Droplet Precautions/Personal Protective Equipment The facility Droplet Precaution signage documented everyone must: Clean hands when entering and leaving room. Medical and staff must use gown, glove, and eye cover if contact with secretions is likely.1.Resident #66 tested positive for influenza A and COVID -19 on 01/05/2026. During an observation on 01/06/2026 at 12:39 PM, the resident had a droplet precautions sign outside of their room and Licensed Practical Nurse #50 was observed entering their room and without eye protection.2. Resident #87 tested positive for COVID -19 on 01/01/2026. During observations on 01/05/2026 at 10:11 AM and 12:38 PM, the resident's had a droplet precautions sign outside of their room. The isolation caddy outside of the room included gowns, masks, but did not contain any eye protection.3. Resident #195 tested positive for influenza A and COVID -19 on 12/31/2025. During an observation on 01/06/2026 at 8:38 AM, the resident had a droplet precaution sign outside of their room and Licensed Practical Nurse/ Assistant Unit Manager #49 was standing at the resident's bedside talking to them. They were not wearing a gown or gloves and just had their prescription glasses on. During an interview Licensed Practical Nurse/ Assistant Unit Manager #49 stated they should have worn a gown, gloves, and a face shield in case they were (continued on next page)

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	335283	A. Building B. Wing	01/09/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	exposed to any secretions. They stated this was an oversight and they knew better. 4. Resident #244 tested positive for influenza A on 01/02/2026. During an observation on 01/06/2026 at 1:32 PM, the resident had a droplet precautions sign outside of their room and Certified Nurse Aide #51 entered the resident's room and did not wear eye protection.5. Resident #268 tested positive for influenza A on 01/03/2026. During an observation on 01/06/2026 at 12:36 PM the resident had a droplet precautions sign outside of their room and Licensed Practical Nurse #50 was observed entering the resident's room and did not wear eye protection. During an observation on 01/06/2026 at 1:24 PM, Certified Nurse Aide #51 was observed entering the resident's room and did not wear eye protection.During an interview on 01/06/2026 12:50 PM Licensed Practical Nurse #50 stated they entered Resident #66's and Resident #268's rooms and did not wear eye protection. Both residents were on droplet precautions. They stated they should wear eye protection when going in the rooms as they could be exposed to secretions.During an interview on 01/06/2026 at 1:37 PM Certified Nurse Aide #51stated Residents #244 and #268 were on droplet precautions and they did not wear eye protection when entering their room. They stated they did not think they would be exposed to possible secretions, so they did not have to wear eye protection. During an interview on 01/09/2026 at 1:31 PM Registered Nurse/ Infection Preventionist #37 stated any residents who tested positive and/or were suspected of having influenza or COVID -19 were placed on droplet precautions and staff were expected to wear a gown, gloves, and eye protection when providing care and during any close contact due to the risk of secretions from droplets. It was the responsibility of all nursing staff to ensure the proper personal protective equipment was available and the facility had plenty of personal protective equipment.10NYCRR 415.19(a)(b)

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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 (continued on next page)

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	335283	A. Building B. Wing	01/09/2026

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had moderate 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, record review, and interviews the facility failed to ensure that when a restraint was indicated, the least restrictive alternative for the least amount of time was used and included ongoing re-evaluation of the need for the restraint for one (1) of one (1) resident (Resident #13) reviewed. Specifically, a crisscross lap belt (a nylon belt around the waist and hooked to the back of the wheelchair) was implemented for Resident #13 and there was no documented evidence the device was determined to be the least restrictive alternative or the need for the device was periodically reevaluated. Findings include: The facility policy Restraints, revised 11/2017, documented the use of restraints for staff convenience, for purposes of discipline, or as substitutes for direct care, activities, and other services was prohibited. Restraint use was limited to circumstances in which the resident had medical symptoms that warranted the use and used only to protect the health and safety of the resident, and to assist the resident to attain and maintain optimum levels of physical and emotional functioning. The use of restraints would be re-evaluated throughout the resident's length of stay. The Interdisciplinary Team would review on an on-going basis to identify opportunities for use of restraint alternatives, less restrictive restraint, and/or restraint removal. The Restraint Evaluation Form, and corresponding Individualized Restraint Reduction Planning Form would be completed with each restraint assessment. A registered nurse was responsible to obtain medical orders and parameters of use, track dates for periodic reassessment with quarterly care planning to assist in the verification of on-going usage, complete the physical device evaluation form, and individualized restraint reduction form. Resident #13 had diagnoses including brain injury, dementia, and difficulty with walking. The 12/09/2025 Minimum Data Set assessment documented the resident had severely impaired cognition; used a manual wheelchair; had no upper or lower extremity impairment; required partial/moderate assistance with chair to bed and toileting transfers, walking 10 feet, and walking 50 feet with two turns; was independent in their wheelchair; had no falls since the prior assessment; and used a truck restraint daily. The 11/4/2020 Restraint Risk Education Form documented the resident used a crisscross restraint for impulsivity and poor safety awareness and was signed by the resident's representative. The 01/23/2024 physician orders documented crisscross lap belt, do not release during meals, release every 2-3 hours and as needed for care. The Comprehensive Care Plan initiated 01/18/2023 and revised 10/29/2025, documented the resident used a physical restraint, crisscross belt related to long standing traumatic brain injury. Interventions included discuss and record with the resident /family/ caregivers, the risk and benefits of the restraint, when restraint should/ would be applied, routine while restrained, any concerns or issues regarding restraint use; ensure the resident was positioned correctly with proper body alignment while restrained; ensure valid consent prior to initiating restraint; monitor/ document/report as needed any changes regarding effectiveness, of restraint, less restrictive device, if appropriate; any negative or adverse effects noted, including decline in mood, change in behavior, decrease in activity of daily living self-performance, decline in cognitive ability or communication. Contracture formation, skin breakdown, and signs/ symptoms of delirium, falls/ accidents/ injuries, agitation or weakness; and release every 2-3 hours, release as needed for care and may release when closely supervised by staff. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/01/2025 Evaluation for Physical Restraint Form completed by Registered Nurse Unit Manager #28 documented the resident had a crisscross belt, they were unable to release it upon request, the device impaired the resident's pre-existing functional ability, and the device was a restraint. The restraint protocol documented to complete the restraint evaluation form, update care plan and plan of care, obtain medical order with medical necessity and parameters of release, periodic re-assessment/ plan to reduce and/or eliminate. There was no documented evidence the crisscross belt was determined to be the least restrictive device, medical symptoms warranted the ongoing use of a physical restraint, or a plan to reduce and or eliminate the restraint was attempted. Resident #13 was observed with a crisscross belt applied around their waist and attached to the back of their wheelchair: - On 01/05/2026 at 10:13 AM and 12:32 PM, while in their room. -On 01/06/2026 at 10:04 AM, while in their room. -On 01/07/2026 at 12:13 PM, while in their room. -On 01/08/2026 at 9:08 AM, while in their room and at 9:45 AM, while self-propelling their wheelchair in the hallway. During an interview on 01/07/2026 at 2:05 PM, Certified Nurse Aide #29 stated if a resident had a restraint it was listed on the care instructions and included when staff were to release the device. Resident #13 had a crisscross belt, and they were unable to release it on their own. Staff applied the device when the resident was in their wheelchair and removed it every 2 -3 hours and during care. They thought the resident had the crisscross belt related to their diagnosis and impulsivity with safety awareness. It served as a reminder to the resident to not stand, as it did not allow them to stand up. They stated the resident had the device for a while and never seen another device attempted. The resident was able to transfer from their chair to toilet or their bed with assistance of one. During an interview on 01/08/2026 at 9:44 AM, Physical Therapist #32 stated they were currently working with Resident #13 on mobility, walking, and safety. The resident was able to walk with assistance of one but was impulsive. The crisscross belt was initiated by nursing in 03/2020. The resident was unable to remove the device on their own, it prevented the resident from rising fully to their feet and was used for safety. They were unsure what alternatives were attempted in the past prior to the initiation of the crisscross belt. Nursing staff were responsible to provide education to the resident/family, obtain consent, and ensure ongoing monitoring/ need for the device. During an interview on 01/01/2026 at 11:23 AM, Licensed Practical Nurse #30 stated Resident #13 had a restraint while they were up in their chair. Staff were to remove the device every 2-3 hours, during care, and as needed. They resident was unable to remove their crisscross belt, and staff monitored their positioning while they were in the chair to ensure they were seated up right. The resident had the device for a couple of years, and it was used for safety. The resident was impulsive and attempted to stand on their own. The crisscross belt prevented the resident from standing and served as reminder to sit down and ask for help. They were unsure if any other devices had been attempted prior to initiation of the crisscross belt or any different devices since the resident was (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their unit. During an interview on 01/09/2026 at 10:17 AM, Registered Nurse Unit Manager #28 stated Resident #13 had a crisscross belt used for safety purposes. The device was used to remind the resident not to stand without help as they were impulsive. it was considered a restraint, as it prevented the resident from standing. The resident had the device in place since they started as the unit manager. They completed the quarterly evaluation to determine if the device was a restraint. They stated there were no attempts to trial any different devices or re-assessment for the reduction of the device. They stated they had not read the facility's restraint policy. During an interview on 01/09/2026 at 11:24 AM, the Director of Nursing stated Resident #13 had a crisscross belt, which was considered a restraint. The resident had the device in place for some time. The device should be reviewed quarterly, annually, and anytime there was a significant change in the resident's status to determine if it was still considered a restraint, if the device remained appropriate to use, and to determine if it was the least restrictive device. It was the responsibility of the nurse manager to evaluate if the restraint was still needed. They should monitor the resident at least quarterly for a restraint holiday (the resident was assigned to one staff member to see how they did without the restraint in place). The findings of the restraint holiday should be documented in the resident's chart. They stated if the nurse manager had any questions regarding the facility policy they should ask nursing administration for clarification. They were unaware there were no attempts to trial different devices or re-assess for reduction. During a telephone interview on 01/09/2026 at 12:02 PM, Physician #34 stated Resident #13 had an order for a crisscross belt, which was in place for some time. The device was used for safety reasons as the resident could be impulsive related to their diagnosis. They were unaware if any different devices were attempted to be used or if a restraint reduction was attempted. They expected the least restrictive device to be used and attempt to assess for reduction of the device if possible. 10NYCRR 415.4(a)(2-7)

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	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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interviews during the recertification survey the facility failed to ensure the development and implementation of a comprehensive person-centered care plan for each resident to include services provided to maintain the resident's highest practicable physical well-being for two (2) of three (3) residents (Residents #195 and #6) reviewed. Specifically, Resident #195's person-centered comprehensive care plan did not include the use of an anticoagulant (blood thinner) and Resident #6's person-centered comprehensive care plan did not include the use of insulin (used to treat high blood sugars) or an anticoagulant.Findings include:The facility policy Comprehensive Care Plans, revised 10/17/2022, documented the facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that would include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in a comprehensive assessment. The comprehensive care plan would be reviewed and revised based on changing goals, preferences, and needs of the resident and in response to current interventions by the interdisciplinary team after each assessment, inclusive of the comprehensive and quarterly review assessments. 1) Resident #195 had diagnoses including history of blood clots, embolism (a blood clot that blocks a blood vessel), and long-term use of anticoagulants. The 12/29/2025 Minimum Data Set assessment documented the resident had moderate cognitive impairment and was on an anticoagulant. The 12/22/2025 physician order documented Eliquis (blood thinner) 5 milligram tablet by mouth two times a day for history of a deep vein thrombosis (blood clots). There was no documented evidence of a person-centered comprehensive care plan that included the use of an anticoagulant or monitoring for symptoms of anticoagulant use. During an interview on 01/09/2026 at 9:28 AM, Licensed Practical Nurse #26 stated they were unsure if an anticoagulant medication should be on the care plan, and they would have to ask the nurse manager. They thought it would be helpful if Resident #195's anticoagulant medication was included in their care plan because they had hematuria (blood in the urine) and sustained a fall so staff should have been aware they were on a blood thinner. During an interview on 01/09/2026 at 9:42 AM, Registered Nurse Manager #4 stated they were unaware Resident #195's anticoagulant medication was not included in their care plan, and it must have been an oversight. Resident #195 was on Eliquis twice a day, had a history of falls, and had recent hematuria. It was important for anticoagulant therapy to be included on the care plan so staff were aware and could monitor for bleeding. 2) Resident #6 had diagnoses including diabetes and atrial fibrillation (irregular heart rhythm). The 12/18/2025 Minimum Data Set assessment documented the resident was cognitively intact and received insulin and an anticoagulant daily. Physician orders documented: -on 12/11/2025, heparin sodium (blood thinner) 5000 units subcutaneously (under the skin) two times a day for deep vein thrombosis prophylaxis (preventative treatment for blood clots). (continued on next page)

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	335283	A. Building B. Wing	01/09/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 12/11/2025, insulin aspart (short acting insulin) inject subcutaneously per sliding scale before meals for diabetes. Notify registered nurse or provider if (blood sugar) was greater than 400 or less than 70 (milligrams/deciliter). -on 12/12/2025, Lantus (long-acting insulin) 30 units subcutaneously at bedtime for diabetes. There was no documented evidence of a person-centered comprehensive care plan that included the use of insulin and monitoring for hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar), or the use of an anticoagulant and monitoring for potential side effects. During an interview on 01/08/2026 at 3:19 PM, Certified Nurse Aide #25 stated they looked at resident's care plans often because it told them everything about the resident and how to safely care for them. They were unsure if medications like an anticoagulant or insulin were included in the care plan, but they thought if Resident #6 was diabetic and on insulin the care plan should include things to monitor for like low or high blood sugar, dizziness, or sweating. They were unsure what to monitor for when a resident was on an anticoagulant medication. During an interview on 01/09/2026 at 9:28 AM, Licensed Practical Nurse #26 stated registered nurses were responsible for initiating and updating care plans. If a resident was a diabetic, it should be in their care plan so staff would know to monitor for signs of hyperglycemia or hypoglycemia. Resident #6's care plan should have included their diabetes diagnosis, they required a fingerstick before meals and at bedtime, and they received insulin. They were unsure if an anticoagulant medication should have been included in Resident #6's care plan but they thought it was important so staff would know to monitor for bleeding or bruising. During an interview on 01/09/2026 at 9:42 AM, Registered Nurse Manager #4 stated the registered nurses were responsible for initiating and updating care plans because licensed practical nurses were not allowed to touch them per the facility policy. All staff were expected to look at resident care plans because the care plan told them everything about the resident and how to care for them. They were not aware Resident #6's care plan did not include insulin or anticoagulant medication use, but it should have so staff knew to monitor for bleeding, and signs of hypoglycemia or hyperglycemia. 10NYCRR 415.11(c)(1)

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	335283	A. Building B. Wing	01/09/2026

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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)

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

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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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	335283	A. Building B. Wing	01/09/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure that residents who required dialysis (used to filter waste products from the blood when the kidneys do not work properly) received such services consistent with professional standards of practice for one (1) of one (1) resident (Resident #134) reviewed. Specifically, Resident #134 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and after dialysis treatments including assessment of the dialysis access site, and consistent ongoing communication and collaboration between the facility and the dialysis center. Additionally, the resident was not always provided a lunch meal on their dialysis days.Findings include:The facility policy Coordination of Dialysis Treatment, revised 1/19/2018, the Dialysis Care Coordination Form accompanied the residents to their treatment. The goal was to facilitate communication between the facility and the dialysis center for the purpose of incorporating pertinent resident information into the resident's plan of care. The nurse manager, charge nurse, or designee was responsible for completing the Dialysis Care Coordination Form and ensuring the form accompanied the resident to the dialysis center for each dialysis treatment. Upon return from dialysis, the licensed practical nurse immediately monitored the status of the resident's access site to observe for bleeding or other complications and followed up as indicated and documented the status of the access site in the resident's health record. The licensed practical nurse also reviewed the Dialysis Care Coordination Form and if it had no feedback from the dialysis center, they called the dialysis center for a verbal update. The unit secretary filed the completed dialysis form in the Correspondence Section of the medical record after review by clinical staff. Resident #134 had diagnoses including end-stage renal (kidney) disease. The 10/31/2025 Minimum Data Set assessment (a health status assessment tool) documented the resident was cognitively intact, did not reject care, and required hemodialysis treatments.The Comprehensive Care Plan initiated 08/18/2025 documented the resident needed hemodialysis related to renal failure. Interventions included dialysis three times a week on Monday, Wednesday, and Friday and not to draw blood or take blood pressure in arm with graft. There was no documented evidence of the location of the dialysis access site, a plan for monitoring of the dialysis access site access site, or completion if pre and post dialysis assessments.The 12/05/2025 updated physician order documented the dialysis three times a week, send communication book and completed form to dialysis. Upon return from dialysis check communication book for any correspondence from dialysis and if nothing documented, contact the dialysis center and document on the form. The communication book must be signed by a registered nurse and placed in the documents area of the chart. The nurse must monitor the residents access site upon return from dialysis for bleeding, edema, or any other complication. There was no documented evidence the dialysis site was monitored or that pre or post dialysis assessments were completed. There were no communication summaries for the month of November 2025.The dialysis communication book dated December 2025-January 2026 documented:-Outpatient dialysis daily treatment summaries were completed by the dialysis facility and included pre and post dialysis weights, blood pressures, any medications administered, or labs obtained for all dialysis days (12/01/2025 no dialysis as resident had a bowel movement), 12/12/2025, 12/15/2025, 12/29/2025, and 01/07/2026). There was no documented evidence the information was reviewed by the facility upon the resident's return. There was no communication to the dialysis center from the facility on 12/01/2025, 12/15/2025, or 12/29/2025. There was no documentation from the facility after the resident returned from dialysis the resident or their access site was assessed on 12/12/2025, 12/15/2025, 12/29/2025, or 01/07/2026. There were multiple entries in the communication book that were not completed, signed, or dated. During an observation on 01/05/2026 at 10:02 AM, Resident #134 was sitting by the elevator with a transportation aide wheeling them onto the elevator to dialysis. Resident #134 asked staff for their lunch. The resident stated they were never sent to (continued on next page)

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	335283	A. Building B. Wing	01/09/2026

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St Camillus Residential Health Care Facility	813 Fay Road Syracuse, NY 13219

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis with their lunch, and they got hungry at dialysis. Certified Nurse Aide # 35 looked in the refrigerator and was not able to locate the lunch then went to the resident's room and brought the lunch from the room to the resident. The resident asked for their communication book that was supposed to be hooked to the back of the wheelchair. Certified Nurse Aide #35 went to the room and got the communication book that was in a black bag and hung it on the back of the wheelchair. During an observation and interview on 01/06/2026 at 12:00 PM, Resident #134 stated they went to dialysis on Monday, Wednesday, and Friday, was picked up at 10:00 AM and returned between 3:00-3:30 PM. Most days they were not sent with a lunch, and they wanted one because they were hungry. By the time they got back to the facility, it was almost dinner and when they did have a bagged lunch they were not as hungry. An (arteriovenous) fistula (a surgically created connection between an artery and a vein for dialysis access) was observed on their left arm. The resident stated most days the nurse did not come in their room when they returned from dialysis, and they never looked at their access site dressing. The resident reported removing the dressing earlier that day and placed it on their wheelchair where it was observed as dry without drainage. The resident stated facility staff never looked at their dialysis site. Sometimes the nurse did take their blood pressure when they returned but not often. During an observation on 01/07/2026 at 10:04 AM, Resident #134 was observed by the elevator in a wheelchair with their coat on and communication binder in a black back hung to the back of the wheelchair. The resident did not have a lunch or bag meal. During an interview on 01/07/2026 at 12:35 PM, the dialysis center nurse stated Resident #134 received dialysis in their center on Monday, Wednesday, and Friday. In the month of December, the resident was seen 12/01/2025 but was sent back to the facility as they had a bowel movement and wanted to be cleaned up. They rescheduled for 12/02/2025 and was seen 12/03, 12/05, 12/08, 12/20, 12/12, 12/15, 12/17, 12/19, 12/26/12/29, and 12/30. The resident was sent to the hospital from dialysis on 12/21/2025 and remained in the hospital until 12/25/2025 and did not receive dialysis at the center while in the hospital. In January 2026, the resident received dialysis on 01/02, 01/05 and was in the facility currently. The nurse stated Resident #134 rarely came to dialysis with the communication form completed, therefore they had no knowledge as to medication changes or changes in medical status. The resident rarely had a lunch and did not have one at the time of their treatment 01/07/2025. During an interview on 01/08/2026 at 11:14 AM, Certified Nurse Aide #35 stated they often were assigned Resident #134 who went to dialysis on Monday, Wednesday, and Friday at 10:00 AM. They helped get the resident cleaned up, toileted, and dressed before dialysis. They sent the resident with a bagged lunch on 01/05/2025 after the resident had asked for it. It came up on the resident's breakfast tray, and they located it in the resident's room and brought it to the resident. Resident #134 asked for their binder on 01/05/2025 and they retrieved the binder and placed it in a bag located on the back of the resident's wheelchair. During an interview on 01/08/2026 at 11:08 AM, Licensed Practical Nurse #36 stated Resident #134 was sent out for dialysis, and they did not do anything special for the resident. They did not complete any paperwork because that was only completed for in-house dialysis residents. They did not do anything when the resident returned from dialysis as they were unaware that anything had to be done upon returned. They were not sure if the resident was sent with a bagged meal and had not seen one as the certified nurse aides normally assisted the resident with dialysis preparation. During an interview on 01/09/2025 at 12:09 PM, the Assistant Director of Nursing stated there was a communication book that went with Resident #134 to all dialysis treatments. Nursing completed the binder before sending the resident to dialysis, so the center was aware of any new orders. The dialysis center completed the binder with treatment findings, blood pressure, weights, and any concerns. The nurse assigned to the resident upon return should check the resident's vitals and their access site to make sure they were not bleeding, and they were stable after treatment. 10NYCRR 415.12(k)

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	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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record review, and interviews during the recertification survey the facility failed to ensure accommodation of resident food preferences for one (1) of two (2) residents (Resident #4) reviewed. Specifically, Resident #4 did not receive double portions at meals as planned. Findings included:The facility policy Accommodation of Needs and Preferences and Homelike Environment, revised 12/2017, documented the facility would identify and provide reasonable accommodation of resident preferences. The facility policy Management of Resident Dining, revised 06/2025, documented food and drink would be provided per the meal ticket. The supervisor would monitor each meal on the tray line to ensure tray accuracy, including portion size of the resident tray.Resident #4 had diagnoses including food insecurity. The 12/13/2025 Minimum Data Set assessment documented the resident was cognitively intact and had diagnoses of protein calorie malnutrition and depression.The 12/10/2025 hospital discharge summary documented Resident #4 was treated for starvation ketoacidosis.The Comprehensive Care Plan initiated 12/11/2025 documented Resident #4 was to receive double portions at meals. The 12/11/2025 Diet Technician #17 progress note documented Resident #4 was a new admission and wanted double portions. The 12/13/2025 Registered Dietitian #16 nutrition assessment documented Resident #4 received double portions for nutrition supplementation and had increased calorie and protein needs to heal wounds.During an interview on 01/05/2026 at 10:00 AM, Resident #4 stated they requested double portions with meals when they were admitted and often did not receive them. They stated they were often still felt hungry after eating the meals and had to rely on other snacks on the unit.During an observation on 01/07/2026 at 12:06 PM, Resident #4 received six (6) ounces of beef stew and one-half (1/2) cup of mashed potatoes. Resident #4's lunch meal ticket, dated 01/07/2026, documented the resident was to receive 12 ounces of beef stew and one (1) cup of mashed potatoes and was verified by Registered Dietitian #19.During an interview on 01/08/2026 at 9:55 AM, Certified Nurse Aide #18 stated residents could have doubles portions if they asked, and they let the dietitians know if they received these requests. They had called the kitchen many times to receive extra food for residents who were still hungry after a meal. Resident #4 complained of hunger after meals and would eat ice cream or something on the unit after they finished the meal. During an interview on 01/08/2026 at 10:11 AM, Licensed Nurse #15 stated Resident #4 often asked for extra food portions at meals, and this was an ongoing issue for them. During an interview on 01/08/2026 at 12:08 PM, Food Service Director #13 stated anybody could have double portions, and when nursing called about missing portions, they brought the extra food to the unit right away. The kitchen staff knew who was on larger portions because it was either underlined or highlighted on the tray ticket. During an interview on 01/08/2026 at 10:25 AM, Registered Dietitian #19 stated Resident #4 was supposed to receive double entree breakfast, lunch and dinner, double starch at lunch and dinner, and double sides at breakfast. 10NYCRR 415.14(d)(3)(4)