

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER Bishop Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 918 James Street Syracuse, NY 13203	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48446</p> <p>52766</p> <p>Based on observations, record review, and interviews during the recertification and abbreviated (NY00375456, NY00376994, and NY00378104) surveys conducted 5/12/2025- 5/16/2025, the facility did not 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 six (6) residents (Residents #145) reviewed. Specifically, Resident #145 was observed with brown debris underneath long, untrimmed fingernails.</p> <p>Findings include:</p> <p>The facility policy Activities of Daily Living Care and Support, revised 2/28/2025, documented activities of daily living care and support was provided to residents who were unable to carry them out independently. Nail care was provided as needed for residents.</p> <p>Resident #145 had diagnoses including cerebral palsy (a disorder that affects movement and coordination), major depressive disorder, and dementia. The 5/1/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not exhibit behavioral symptoms, did not reject care, and was dependent for most activities of daily living.</p> <p>The Comprehensive Care Plan initiated 12/4/2023 and revised 5/16/2025, documented the resident required assistance with self-care and mobility related to cerebral palsy and intellectual disabilities. Interventions included dependence for all activities of daily living. The resident communicated by nodding their head to answer yes or no questions.</p> <p>The undated care instructions (Kardex) documented the resident required maximum assistance with personal hygiene and was dependent for all hygiene needs.</p> <p>During observations on 5/12/2025 at 10:55 AM, 5/14/2025 at 3:19 PM, and 5/15/2025 at 8:03 AM Resident #145 had long, untrimmed fingernails with a brown and black substance underneath the nails.</p> <p>The 5/2025 certified nurse aide activities of daily living log documented the resident was bathed during the evening shift on 5/13/2025 by Certified Nurse Aide #8.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/15/2025 at 8:10 AM, Certified Nurse Aide #8 stated they were responsible for providing hygiene care for residents on shower days and as needed. Hygiene care on shower days included washing the resident, washing hair, brushing teeth, and clipping nails. Residents should not have long and unclean nails. Nails should be cut and cleaned even if it was not their shower day. They did not notice resident #145's nails that morning because night shift got them up and into their chair for the day. They stated long and dirty nails was a source of infection.</p> <p>During an interview on 5/16/2025 at 7:40 AM, Certified Nurse Aide #9 stated they worked overnights on 5/14/2025 and 5/15/2025, and got the resident cleaned up and out of bed. They did not clean the resident's nails because they did not notice they were dirty. Resident #145 fed themselves and it was an infection control issue if they had unclean fingernails. Fingernail care was done any time a resident asked and on their shower day.</p> <p>During an interview on 5/16/2025 at 9:31 AM, Licensed Practical Nurse #7 stated certified nurse aides provided nail care to residents if they were not diabetic. Nail care was important to prevent infection. Resident #145 had not refused care and should have their nails clipped and cleaned.</p> <p>During an interview on 5/16/2025 at 11:24 AM, Assistant Director of Nursing #3 stated certified nurse aides did all the activities of daily living care, which included cutting and cleaning the nails. They did not expect to see brown and black substances under fingernails and long nails as it was a dignity and hygiene issue, and they could also cut or hurt themselves.</p> <p>10 NYCRR 415.12(a)(3)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>40803</p> <p>Based on record review and interviews during the recertification and abbreviated (NY00375456) surveys conducted 5/12/2025 - 5/16/2025 the facility did not ensure residents were free of significant medication errors for one (1) of one (1) resident (Resident #47) reviewed. Specifically, on 4/9/2025 Licensed Practical Nurse #4 administered Resident #47 medications ordered for Resident #116. This resulted in past non-compliance with no actual harm with potential for more than minimal harm.</p> <p>Findings include:</p> <p>The facility policy Medication Administration, revised 12/2019, documented medications should be administered in a safe and timely manner, and as prescribed. The individual administering the medication must check the label three (3) times to verify the right medication, right dosage, right time and right method (route) of administration before giving the medication. Medications ordered for a particular resident may not be administered to another resident.</p> <p>Resident #47 had diagnoses including schizophrenia, dementia, congestive heart failure (heart does not pump blood well), and chronic obstructive pulmonary disease (lung disease). The 2/5/2025 Minimum Data Set assessment documented the resident was cognitively intact, independent with activities of daily living, and did not take insulin.</p> <p>Resident #116 had diagnoses including diabetes, schizoaffective disorder (mental illness), and chronic obstructive pulmonary disease (lung disease). The 2/24/2025 Minimum Data Set assessment documented the resident was cognitively intact, dependent for most activities of daily living, and received daily insulin injections.</p> <p>The facility investigation form dated 4/13/2025 documented on 4/9/2025, Resident #47 experienced a medication error involving the administration of both long and short-acting insulin, psychotropic, and antihypertensive (used for high blood pressure) medications, not prescribed to them. The resident exhibited asymptomatic (not exhibiting symptoms) hypoglycemia (low blood sugar) and hypotension (low blood pressure). Vital signs were closely monitored, intravenous fluids were provided as a preventative measure, and the resident received glucagon (used to treat low blood sugars) four (4) times at regular intervals for asymptomatic hypoglycemia. The error occurred due to a new nurse (Licensed Practical Nurse #4) failing to correctly identify the resident before administering medications. Following the reporting of the medication error, Licensed Practical Nurse #4 was removed immediately from medication cart responsibilities.</p> <p>The facility investigation included an interview with Licensed Practical Nurse #4. Licensed Practical Nurse #4 stated they parked the medication cart between the rooms of Resident #116 and #47, mistakenly entered Resident #47's room, and advised Resident #47 they were going to administer their medications and insulin and the resident said okay. When they returned to the medication cart, they realized they entered the wrong room (Resident #47's room), and they immediately notified the Nurse Manager (unidentified) of the error. The Registered Nurse and Nurse Practitioner were also informed and came to assess the situation. A written statement by Licensed Practical Nurse # 4 indicated they checked the resident's blood pressure and blood sugar, entered the blood sugar into the computer which prompted them to give the insulin.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 4/9/2025 Nurse Practitioner #5 progress note documented the resident was seen for an acute visit due to hypotension. Nursing staff reported gradual onset of symptomatic hypotension and borderline hypoglycemia. The resident reported feeling lethargic and dizzy and was very confused at baseline due to advanced dementia. Objective data included vital signs of 80/62 (hypotensive), glucose 184 (normal fasting for non-diabetic 70-99 milligrams /deciliter) and oxygen saturation of 91% on room air. Oxygen via nasal cannula at 2 liters was applied and oxygen saturation increased to 98%. Heart rate initially was 49 beats per minute (normal 60-100) and increased to 63 beats per minute after glucagon was administered. The plan included to provide one (1) liter of normal saline intravenously for hypotension and monitor vital signs closely. For the borderline hypoglycemia with intermittent lethargy the resident responded well to the intramuscular injection of glucagon. Orders to monitor blood glucose closely and administer glucose if blood glucose falls below 70. Labs were ordered to check for infection indicators and electrolyte imbalances.</p> <p>Lab results for labs collected on 04/10/2025 at 08:22 indicated Urea Nitrogen; Creatinine and BUN/Create Ratio were elevated and Neutrophil % was elevated and Lymphocyte % was low based on the laboratory identified reference range.</p> <p>The 4/9/2025 physician order for Resident #47 documented blood glucose monitoring every hour, notify medical if below 80 milligrams/deciliter or above 400 milligrams/deciliter every two (2) hours for blood glucose monitoring; obtain complete blood count with differential (blood test used to evaluate overall health and detect a variety of disorders), and comprehensive metabolic panel (blood test that measures proteins, enzymes, electrolytes, minerals, and other substances) one time only for renal function; monitor vital signs every hour and record every two (2) hours for monitoring; provide 1 liter of 0.9% normal saline bolus for hypotension for one (1) day; provide one (1) application of glucose oral gel 40% (dextrose, a sugar) by mouth one time only for fasting blood sugar of 83; and provide 1 milligram of glucagon HCL intramuscularly (injection in muscle) every 15 minutes as needed for hypoglycemia for 3 days as needed.</p> <p>Narrative assessments for Resident #47, completed by the Director of Nursing, included the following:</p> <ul style="list-style-type: none"> - on 4/9/2025 12:00, the resident was assessed for a report of a medication interaction. The nurse practitioner and physician were made aware. The resident had fluctuations in consciousness, and intermittent alertness and lethargy. - on 4/9/2025 1500, the resident was re-assessed and alert and responsive, fluctuation in blood sugars was noted, and intravenous fluids were infusing. Resident ate 30% of lunch. - on 4/10/2025 11:30, the resident was re-assessed for follow up medication interaction. The resident was alert, oriented X2, ate 75 to 100% of breakfast, and reported feeling better. Vital signs are stable. <p>The medication administration record for Resident #47 documented their blood sugar was 146 milligrams/deciliter, and they received glucagon 1 gram injection for hypoglycemia on 4/9/2025 at 10:37 AM. They received glucose oral gel at 4:40 PM. On 4/10/2025, the resident received the glucagon injection at 12:36 AM for a documented blood sugar of 69 milligrams/ deciliter at 12:35 AM, and at 4:32 AM for blood sugar documented 83 milligrams/ deciliter at 4:07 AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Licensed Practical Nurse #4 was an agency staff nurse and no longer worked at the facility. On 5/14/2025 at 12:32 PM, 12:41 PM, 1:39 PM, and on 5/15/2025 at 1:39 PM, attempts were made to interview Licensed Practical Nurse #4 via telephone with no response prior to survey exit.</p> <p>During an interview on 5/14/2025 at 11:16 AM, Licensed Practical Nurse Assistant Unit Manager #7 stated they were made aware Resident #47 received Resident #116's medications on 4/9/2025. Licensed Practical Nurse #4 administered medications intended for Resident #116 to Resident #47. Licensed Practical Nurse Assistant Unit Manager #7 stated they were unsure which medications were administered to Resident #47. Following the incident Licensed Practical Nurse #4 was asked to leave the unit. They stated they were asked to take over Licensed Practical Nurse #4's assignment for the remainder of the day. Registered Nurse Unit Manager #6 notified the medical provider, Assistant Director of Nursing #3, and the Director of Nursing. They stated Resident #47 was closely monitored by Registered Nurse Unit Manager #6.</p> <p>During an interview on 5/14/2025 at 12:57 PM, Registered Nurse Unit Manager #6 stated Licensed Practical Nurse #4 never worked on the unit prior to 4/9/2025. Licensed Practical Nurse #4 came to them on 4/9/2025 during the morning medication pass and told them they had accidentally administered Resident #116's diabetic medications to Resident #47. Registered Nurse Unit Manager #6 stated Resident #47 was not prescribed diabetic medications, and they alerted Assistant Director of Nursing #3, the Director of Nursing, and medical about the incident right after they were notified of the error on 4/9/2025. Licensed Practical Nurse #4 was asked to leave the facility pending an investigation and Licensed Practical Nurse Assistant Unit Manager #7 took over for Licensed Practical Nurse #4. Registered Nurse Unit Manager #6 stated they were asked to stay with Resident #47 and monitor the resident for the remainder of their shift. Resident #47 was prescribed intravenous fluids, glucagon, and monitored per medical orders.</p> <p>During an interview on 5/14/2025 at 2:01 PM, Nurse Practitioner #5 stated they were notified in the morning on 4/9/2025 that Resident #47 received Resident #116's short and long-acting insulins. They immediately went to assess Resident #47. They stated the resident's blood sugars were fine, and the resident received glucagon to help prevent their blood sugars from dropping. The resident also received intravenous fluids as their blood pressure was low, but that was likely a coincidence of not drinking enough fluids. The resident was tired, and they perked up after receiving glucagon. Nurse Practitioner #5 stated they remained in the room with the resident, and the resident was stable. They notified the Medical Director of the issue after they assessed the resident on 4/9/2025. After the incident, they reviewed both resident's medication lists for any issues.</p> <p>During an interview on 5/15/2025 at 10:14 AM, the Medical Director stated they were made aware of the medication event by Nurse Practitioner #5 on 4/9/2025 in the morning. Resident #47 was not prescribed insulin and received a good dose. The resident received intravenous fluids for low blood pressure and glucagon a couple of times. The resident was closely monitored and remained stable and did not require hospitalization following the event.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/15/2025 at 10:14 AM, the Director of Nursing stated they were notified about the medication error by Registered Nurse Unit Manager #6 between 9:30 AM and 10:00 AM on 4/9/2025. They started an investigation on 4/9/2025 and completed it on 4/13/2025. They stated they did a complete nursing assessment of Resident #47 at the time of the incident. Nurse Practitioner #5 was also at the bed side. Licensed Practical Nurse #4 stated they parked their medication cart between rooms and prepared the medications for Resident #116 and entered Resident #47's room in error. Licensed Practical Nurse #4 realized the error when they returned to the medication cart and immediately reported this to Registered Nurse Unit Manager #6. The resident received insulin, antihypertensives, and antipsychotics.</p> <p>During an interview on 5/15/2025 at 1:43 PM, Pharmacist #26 stated the facility contacted them regarding a medication error with Residents #47 and #116. The Medical Director was notified, and they did not feel any additional interventions were needed as everything being done was appropriate.</p> <p>An interview was attempted with Resident #47 during the morning hours; however, resident was non-responsive, at baseline per staff who indicated resident isn't responsive until the afternoon.</p> <p>During an interview on 5/14/2025 at 10:00 AM Certified Nurse Aide #28 stated the resident liked to sleep in the morning and did not perk up until the afternoon.</p> <p>Past non-compliance: There is sufficient evidence to determine that the facility immediately took proactive steps to prevent injury to the resident and to correct the noncompliance and was in substantial compliance with regulatory requirements at the time of the current survey.</p> <p>10 NYCRR 415.12(m)(2)</p> <p>48895</p>		