STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews (IQIES Intake 2801048), the facility failed to ensure all services being provided met professional standards of quality for one (1) of three (3) residents reviewed (Resident #5). Specifically, Resident #5 had an unwitnessed fall on 03/06/2026, was sent to the emergency department for evaluation and was diagnosed with a left proximal humerus fracture (left upper arm broken bone). The facility failed to implement the hospital discharge instructions for the resident's arm fracture, complete a re-admission reassessment, notify the medical provider to update the medical orders for the sling, and update the comprehensive care plan when they returned to the facility on [DATE]. Findings include:The 09/2022 revised facility policy, Admission-Readmission, documented when a resident was admitted /readmitted to a nursing unit, the nurse must complete the Licensed Nurse admission Assessment within the electronic health record. The 05/28/2025 facility policy, Professional Standards of Quality and Practice, documented care and all services were provided according to accepted standards of clinical practice. Resident #5 had diagnoses of malignant neoplasm of the rectum (rectal cancer), muscle wasting and atrophy, and unspecified intellectual disabilities. The 03/11/2026 Minimum Data Set (assessment tool) documented the resident's cognition was not assessed, they required substantial to maximum assistance with toileting, bathing and lower body dressing, partial to moderate assistance with oral hygiene, personal hygiene and transfers from bed/chair to bed, and supervision with walking ten feet. The 03/04/2026 admission Assessment documented Resident #5 had bilateral bruises on their arms, bruising on their abdomen, no history of falls in the past six months and had normal range of motion in their left and right upper extremities.The comprehensive care plan, initiated 03/04/2026, documented that they were at a risk for falls or had an actual fall related to deconditioning. Interventions included: call bell within reach; wear non-skid slipper socks; anticipate needs; physical therapy/occupational therapy evaluation and treat as needed; maintain a clutter-free environment; and toileting assistance as needed and per therapy recommendations. 03/04/2026 Physician's Orders documented acetaminophen (a pain-relieving analgesic) 325 milligrams, take two (2) tablets by mouth every six (6) hours as needed for pain for 10 days. Do not exceed three (3) grams in 24 hours.The 03/06/2026 at 6:30 PM Facility Accident/Incident Investigation Report documented Resident #5 had an unwitnessed fall and was transferred to the hospital emergency department for evaluation of a left forehead hematoma (bruise and bleeding under the skin) and to rule out a left humerus (upper arm) fracture. The following actions were documented as being done after the resident was found on the floor: neurological checks initiated; first aid initiated; call bell in reach with instruction; assisted to standing position; notified on-call medical provider; notified immediate supervisor; notified resident representative; updated the care plan and Kardex; range of motion assessment; skin assessment; placed in bed; and outside services required. The investigation summary documented Resident #5 returned to the facility (03/07/2026) with a fracture to their left upper arm, was given a sling for conservative management, there was no care plan violation, and the resident would be referred to physical and occupational therapy. The Facility Accident/Incident Investigation Report was signed off by the Director of Nursing on 03/18/2026 at 5:33 PM.The 03/06/2026 at 7:14 PM facility Hospital Transfer Form, signed by (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse Supervisor #3, documented Resident #5 was sent to the hospital for evaluation of a left forehead hematoma and left shoulder pain after a fall. The 03/06/2026 at 7:33 PM Nursing Progress Note by Registered Nurse Supervisor #3 documented Resident #5 had a fall in their room and was found on the floor. They sustained a hematoma on their left forehead, complained of excruciating pain to their left shoulder, and they were unable to perform range of motion. The on-call medical provider was notified. The 03/07/2026 Hospital Emergency Department Summary documented extensive laboratory and diagnostic tests that were performed once the resident was admitted [DATE] through 03/07/2026, to include a computed tomography scan (CT scan) of their head that revealed an intraparenchymal hemorrhage (hematoma) to their left forehead, and an x-ray of their left arm that revealed a left proximal humerus fracture (left upper arm broken bone). There were no interventions necessary for the left forehead hematoma as the resident was stable with normal vital signs. Orthopedic recommendations were: keep left arm sling clean, dry and intact; remove sling intermittently to work on pendulum swing exercises and passive range of motion about the shoulder; elevate extremity; return to emergency department if decreased capillary refill or discoloration of fingers; pain medication per emergency department; non-weight bearing to left upper extremity; and follow up with the orthopedic physician in one week. The resident was discharged from the Hospital Emergency Department 03/07/2026 at 3:19 PM. The 03/07/2026 Nursing Progress Note by Registered Nurse Supervisor #3 documented Resident #5 returned from the hospital at 3:50 PM, and, after meticulous testing at the hospital emergency department, no acute or critical conditions were found. The resident's care was ongoing.There was no documented evidence on 03/07/2026 that a readmission assessment was completed by a registered nurse, a medical provider was notified of the resident's return, or that hospital discharge orders were implemented.Resident #5's 03/07/2026 revised care plan documented limited physical mobility related to weakness. Interventions included: orient to call light/safety measures; engage resident in fall/injury preventions; initiate interventions to prevent skin breakdown/injuries; invite resident to activity programs that encouraged activity/physical activity; and to help with positioning. There was no documentation that the resident had a left fractured humerus that required the use of an arm sling.A 03/07/2026 at 11:33 PM Nursing Progress Note by Licensed Practical Nurse #13 documented the resident complained of pain and was resting in their bed with their eyes closed at that time.There was no documented evidence pain medication administered on evening shift of 03/07/2026 related to License Practical Nurse #13's 03/07/2026 at 11:33 PM Nursing Progress Note.A 03/11/2026 Physical Therapy note documented the resident had minimal progress, had multiple falls and had declined therapy treatment. They were discharged from therapy 03/10/2026.During an interview on 03/20/2026 at 10:43 AM, Registered Nurse Supervisor #3 stated they recalled the resident returning from the hospital (03/07/2026) with a sling on their left arm. They reviewed the hospital paperwork but did not see and was not aware the resident had a fracture to their left arm. The hospital paperwork only addressed the resident's rectal cancer diagnosis (which was already known to the facility).During an interview on 03/20/2026 at 3:15 PM, Certified Nurse Aide #4 stated they cared for Resident #5 after they returned from the hospital (03/07/2026). The emergency medical technicians handed them paperwork for the nursing supervisor, and they placed it on the desk at the nurse's station. Resident #5 had a black-colored sling on their left arm when they returned. Resident #5 would occasionally take the sling off. The resident was able to communicate and make requests but did not verbalize pain. They were not informed of how to care for the resident's sling or that the resident had a fracture to their left arm.During an interview on 03/20/2026 at 12:25 PM, Nurse Practitioner #8 stated they had no knowledge of Resident #5's fracture to their left arm and would have expected a medical provider to be notified when they returned from the emergency department 03/07/2026. It was important to call the hospital to obtain the hospital after-visit summary to see what treatment was given and what care was needed upon return. They would never re-admit a resident without having the proper documentation. Registered Nurse Supervisor #3 did not do a re-assessment, notify a medical provider or obtain an order for the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's sling. A sling would have required a physician's order. Direct care staff would have needed to know how to care for the resident with their fractured left arm, especially for transfers. During an interview on 03/23/2026 at 11:49 AM, Physician #9 stated they were not aware of Resident #5's left humerus fracture after their fall on 03/06/2026 and subsequent transfer to the emergency department (the on-call medical provider was notified 03/06/2026 and it was not Physician #9). It was important to phone the hospital and find out what evaluations were completed and what treatments were implemented, including imaging, as it would change the resident's plan of care. If staff had no knowledge of a fracture, it could cause further harm to the resident. The resident's Physician's Orders showed acetaminophen as needed for pain (start date of 03/04/2026), but the resident did not receive any from 03/04/2026 to 03/11/2026. During an interview on 03/23/2026 at 1:00 PM, Physical Therapist #14 stated Resident #5 required contact guard assistance with their activities of daily living. When the resident was receiving therapy on 03/10/2026 they observed the resident's left arm, which was black and blue from the shoulder down to the elbow. The resident was attempting to use their walker and they could not raise their left arm. The resident verbalized that it hurt. They reported that information to the 4 North Unit nurse (they could not recall the nurse's name). They had not been informed Resident #5 had a left arm fracture. If they had known Resident #5 had a fracture to their left arm it would have changed their plan of care. During an interview on 03/23/2026 at 1:15 PM, Occupational Therapist #15 stated they heard Resident #5 fell and went to the hospital (03/06/2026). They were unaware the resident had a fracture to their left arm, and if they had known, they would not have used the resident's left arm until an order from an orthopedic physician was obtained. During a follow-up interview on 03/23/2026 at 03:06 PM, Registered Nurse Supervisor #3 stated when a resident returned from the hospital less than 24 hours later, they did not always return with after-visit summary discharge paperwork. They recalled Resident #5 having paperwork and remembered seeing a sling. They were not aware of the fracture, did not phone a physician or obtain orders for the sling. During an interview on 03/23/2026 at 4:30 PM with the Administrator, they stated the Interdisciplinary Team discussed every nursing unit in morning report regarding residents' changes in condition, room changes, facility census and resident consultation reviews. They were not aware of Resident #5's left arm fracture. The hospital discharge paperwork was printed by the facility on 03/10/2026. The facility investigation into Resident #5's fall on 03/06/2026 was started by Registered Nurse Supervisor #3 and it was signed off by the Director of Nursing on 03/18/2026. During a phone interview on 04/01/2026 at 12:40 PM, Licensed Practical Nurse #21 stated they remembered putting the left arm sling on Resident #5 on several occasions and adjusting it when the resident tried to remove it, but they did not know why the resident had a sling. They were unaware the resident had a left fractured humerus (after being told during the phone interview). The resident's left arm sling would have been in the Treatment Administration Record (it was not). They could not remember for certain if staff from therapy approached them about the resident not having range of motion in their left arm and that it should be evaluated for a possible fracture, but they may have. They would have notified their supervisor about therapy's concerns. They did recall the resident fell frequently. 10 NYCRR 415.11(c)(3)(i)