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	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews (IQIES intake 2799654), the facility failed to ensure a safe, clean, comfortable, and homelike environment for four (4) of seven (7) resident units (Units 2, A, D and C) and one (1) of one (1) resident (Resident #333) reviewed. Specifically, Resident #333 was not provided with a key to a nightstand drawer to secure valuables; Units A and D had clogged, sinks with foul smelling water; Unit C had areas that were unclean and in disrepair: and Unit 2's tub room had an active leak. Findings include:The facility policy Homelike Environment, dated 9/19/2022, documented residents were to be provided with a safe, clean, comfortable, and homelike environment. The residents were to have a facility that had pleasant neutral smells, inviting colors and décor, and cleanliness and order. The1/16/2023 facility admission Agreement documented each resident had a locked drawer in their room for storage of personal property. The facility policy Personal Property, revised 12/17/2025, documented a locked drawer in the resident's room was available as needed if the resident wished to secure personal items or valuables. 1) Resident #333 had diagnoses including anxiety and depression. The 4/21/2026 Minimum Data Set assessment documented the resident was admitted to the facility from the hospital. The comprehensive admission assessment had not yet been completed. The 04/23/26 at 9:22 PM and 9:38 PM Social Worker #22 progress notes documented the resident was met at their bedside and all admission paperwork was signed. The resident was able to make needs known and was admitted for short term rehabilitation. A copy of the residents' rights was provided. During an interview on 04/27/2026 at 4:51 PM, Resident #333 stated they were unable to lock their nightstand drawer as they did have a key. The resident stated they told multiple staff members since they were admitted they would like a key. During an interview and observation on 04/30/2026 at 12:12 PM, Resident #333 stated they still had no key to the nightstand lock. They wanted to ensure certain personal items did not wind up missing and had no way to lock it. A wallet, loose coins, and other personal items were observed in the nightstand top drawer. During an interview on 05/01/2026 at 2:06 PM, the Administrator stated all residents should be offered a key to the locked nightstand upon admission. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/2026 at 2:27, Licensed Practical Nurse Manager #5 stated nightstand drawer keys should be offered to each resident on admission. Admitting staff put in a maintenance request to get the key for the resident. They stated they admitted the resident to the facility and the resident refused one at the time. The manager stated they did not enter a note in the resident's record that the resident refused a key. and staff normally did not document the offering of a key. During an interview on 05/01/2026 at 2:59 PM, Registered Nurse Manager #23 stated they had just made aware last night (04/30/2026) that the resident wanted a nightstand drawer key to secure their wallet for safeguarding. The manager stated they then put in a maintenance request for a key. The manager stated that if a resident requested a key to the locked drawer, any staff member was able to enter the work order and then maintenance would bring them a key by the next morning. They did not know why the resident never received a key since admission. 2) During observations on 04/27/2026 at 9:44 AM and 04/30/2026 at 11:21 AM, the hand sanitizer dispenser in the hallway outside of Room C30 was broken. During an observation on 04/27/26 at 09:49 AM, the janitor's closet by Room D13 had a clogged sink with several inches of dark stagnant liquid in the basin with a strong foul odor. During an observation on 04/27/26 at 11:20 AM, the janitor's closet by Room A33 had a clogged sink with several inches of dark stagnant liquid in the basin with a strong foul odor. During an observation on 04/27/2026 at 11:24 AM, the second-floor tub room had an active leak. During an observation on 04/27/2026 at 1:36 PM, Room CS 28 had a large piece of tile (approximately 6 inches in diameter) missing in the room outside the bathroom. During an observation on 04/27/2026 at 2:06 PM, Unit C room [ROOM NUMBER] had dirty linens on the floor including a gown and washcloths. Licensed Practical Nurse #24 walked into the room, left the dirty linen on the floor, and told the resident to put on their oxygen. A certified nurse aide came out of the room and asked another aide where the bags were. The other aide said they could not find any and the unit housekeeper was on break. The dirty linens remained on the floor. During observations on 04/29/2026 at 11:49 AM and 04/30/2026 at 10:13 AM, there was a half piece of tile missing near the Unit C double doors by the bulletin board. During observations on 04/29/2026 at 12:06 PM and 04/30/2026 at 10:26 AM, Room C35-W had brown spots on the ceiling. During an observation on 04/30/2026 at 9:27 AM, the surveyor turned on the call bell for Room C20 and the light did not turn on above the hallway door. During an interview and observation on 04/30/2026 at 9:28 AM Certified Nurse Aide #26 stated if a resident needed something, they should put their call bell on. If a resident could not push the button, they were provided with a tap bell. They were aware Room C20 did not have a functioning call bell. It did not ring, but it would blink over the door. If the call bell did not light up, staff should put in a work order and maintenance would fix it. The aide was not sure if maintenance was notified the bell was not ringing. The aide went into Room C20, pushed the call bell and stated it was lighting up. It just had to be pushed hard. The bell did not alarm at the nurse's station. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2026 at 9:37 AM, Licensed Practical Nurse #24 stated a resident called for assistance by either putting their call bell on or they yelled out. The aide should call the supervisor if the call bell did not work. Room C20's call bell did not ring but lit up. They stated they notified a supervisor about the resident's call bell but did not remember who. The resident called the nurse's station when they needed something. During an interview on 04/30/2026 at 11:18 AM, Licensed Practical Nurse #27 stated linen should not be on the ground for infection control reasons. Work orders for maintenance should be put in if there was a splatter on the wall, or a broken soap dispenser. Maintenance was called directly for emergencies like a toilet overflowing. The nurse went into Room C35 and said the spots on the ceiling were not homelike. At 11:25 AM, the nurse went to soap dispenser, stating it was broken, and could not be used for appropriate hand hygiene. During an interview on 04/30/2026 at 12:05 PM, Certified Nurse Aide #28 stated linen went in a bag and down the laundry chute. There were times when bags for laundry were not readily available and had to be obtained from housekeeping. There was a short supply of bags. Dirty linen should not be on the floor as it was an infection control issue. During an interview on 04/30/2026 at 12:13 PM, Licensed Practical Nurse Manager #5 stated a work order should be put in for normal repairs. Maintenance should be called for emergencies. Triage of the situation was done by maintenance, and normal repairs were completed within 48-72 hours. Hand sanitizer dispenser was used for infection control purposes. It was a tripping hazard and not homelike if floor tiles were missing. The manager stated they had not put in a work order for the dirty ceiling tiles and should have, as it was not homelike in appearance. There should be no linens left on the floor for infection control purposes, and they were also a tripping hazard. During an interview on 04/30/2026 at 1:21 PM, the Director of Maintenance stated any maintenance concerns required a work order to be placed by staff. The director was unaware of the clogged sinks, active leaks, and foul odors that were present in the areas. The director stated the department had not received any work orders for or they would have been fixed. During an interview on 05/01/2026 at 9:37 AM, the Director of Maintenance stated the maintenance department was responsible for maintaining the building and fixing concerns, such as broken soap dispensers, replacing broken tiles, and fixing ceiling splatters. Staff were to put in work orders that were triaged by the department. Urgent issues should be addressed to the department. It usually took less than 24 hours to complete an issue, based on the severity. The department met every day to prioritize work orders. The director did not remember any work orders for the observed conditions. 10 New York Codes, Rules and Regulations 415.29(j)(1)

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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 (iQIES Intake 2799654, 2969603, and 2969139) the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (1) of eight (8) residents (Resident #100) reviewed. Specifically Resident #100 was not toileted or changed when they were soiled. Findings include:Resident #100 had diagnoses including hemiplegia (one sided loss of function) following a stroke, depression, and morbid obesity. The 04/13/2026 Minimum Data Set assessment documented the resident had intact cognition, required substantial/maximum assistance with showering, was dependent on toileting and rolling in bed, was frequently incontinent of urine and bowel, was at risk for developing pressure injuries, had unhealed pressure injuries, had three Stage 2 (partial thickness tissue loss) pressure ulcers, and did not reject care.The comprehensive care plan documented:-initiated 04/12/2024 and revised 09/16/2025, the resident had bowel incontinence related to impaired mobility and hemiplegia. Interventions included toileting every 2-4 hours with peri care after each incontinent episode.-initiated 05/11/2024 and revised 10/01/2024, the resident had bladder incontinence related to impaired mobility, diabetes, and history of prostate cancer. Interventions included application of incontinence devices, provide toileting care every 2-4 hours, and monitor for signs of urinary tract infection including pain, burning, blood-tinged urine, frequency, and changes in behavior. The undated certified nurse care instructions documented the resident required being checked and provided toileting care every 2-4 hours and the resident was dependent on staff for toileting needs.The Certified Nurse Aide documentation documented bowel and bladder toileting care every 2-4 hours care was not completed for Resident #100 on:Day shifts on 02/03/2026, 02/13/2026, 03/18/2026, 03/21/2026, 04/01/2026, 04/04/2026, and 04/13/2026.Evening shifts on 02/15/2026, 03/15/2026, 0323/2026, 03/28/2026, 04/12/2026, 04/17/2026, 04/19/2026, 04/20/2026, and 04/26/2026. Night shifts on 02/09/2026, 02/10/2026, 02/11/2026, 02/13/2026, 02/15/2026, 02/17/2026, 02/23/2026, 02/24/2026, 02/25/2026, 02/28/2026, 03/23/2026, 03/31/2026, 04/23/2026, 04/25/2026, and 04/30/2026. During an observation and interview on 04/27/2026 at 9:54 AM, Resident #100 was in bed on their back in bed. They stated they were not cleaned when they were wet or soiled and now, they had sores on their buttocks. They were unable to move independently because they had a stroke. The following was observed during an uninterrupted observation on 04/29/2026 from 4:42 AM until 10:26 AM: -at 5:40 AM, an unidentified certified nurse aide from the south unit entered the resident's room and removed a clean brief from the resident's dresser and left the room, they did not provide care to the resident. -at 8:10 AM Certified Nurse Aide #30 entered the room, the resident was observed on their back, stated they were wet, and wanted a cup of hot water. Certified Nurse Aide #30 did not check or change the resident or return with their hot water. -No care was provided to the resident from 8:10 AM-10:26 AM. During an observation and interview on 04/29/2026 at 10:26 AM, Certified Nurse Aide #68 stated they normally provided care to Resident #100 around 11:00 AM however, they were starting early because the resident was getting a treatment to their buttocks by physical therapy at 11:00 AM. Certified Nurse Aide #68 asked Certified Nurse Aide #30 for assistance with providing care because the resident required assistance of two for bathing and changing. The resident was wearing an adult incontinent brief that was saturated with urine and had a large amount of loose brown stool. Certified Nurse Aide #30 stated the resident was soaked with urine many times when they worked and was left soaked from the night shift. They stated when residents were not checked and changed, they could develop skin breakdown, and Resident #100 had skin breakdown on their buttocks and upper thigh. Resident #100 stated they spoke to Licensed Practical Nurse Unit Manager #5 and set up a turning and toileting schedule which was agreed to be completed every 2 hours, however not every staff completed this. During an interview on 05/01/2026 at 12:02 PM Physician #38 stated it was important to keep residents clean and dry to prevent skin breakdown and promote wound healing. Incontinent (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents should be checked every 2 hours to ensure they were not wet or soiled. When a resident had a known area of skin breakdown on their buttocks it was even more important for them to be changed frequently as urine and stool could contaminate the wound and impede wound healing. It only took 9 minutes of sitting in urine or stool for tissue to be impacted and 90 minutes of sitting in urine or stool for a wound to develop. During an interview on 05/01/2026 at 1:19 PM, Licensed Practical Nurse #27 stated it was important to turn and position residents and keep them dry to promote good skin integrity and prevent skin breakdown. They should be checked every 2 hours with particular attention to incontinent residents. Residents should not be in the same position, wet, or soiled for 6 hours. Resident #100 was a priority for checking and changing because they were incontinent and had skin breakdown. During an interview on 05/01/2026 at 2:40 PM, Licensed Practical Nurse Unit Manager #5 stated they expected certified nurse aides to complete rounds every 2 hours to check for incontinence and reposition residents in effort to prevent moisture associated skin damage and skin breakdown. Resident #100 was incontinent of urine and stool, was dependent on two for turning and changing wet or soiled incontinent briefs, and had both moisture associated skin damage and skin breakdown. Night shift staff should complete incontinent care before leaving their shift. 10 New York Codes Rules Regulations 415.12(a)(3)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews (IQIES 2984903), the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection and prevent new ulcers from developing for five (5) of seven (7) residents (Residents #4, # 8, #13, #100, and #209) reviewed. Specifically: - Resident #8 had multiple pressure ulcers including a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer on the sacrum (lower back between the hip bones) that were not routinely assessed (determining stage, size and wound characteristics, appropriateness of treatment) by a qualified individual; newly identified pressure ulcers were not assessed by a qualified individual; pressure ulcer status was determined by a non-qualified individual and the wound evaluations were inconsistent and either included pressure ulcers not previously documented or did not include pressure ulcers that were previously identified. -Resident #209's pressure ulcers were not assessed by a qualified individual upon readmission to the facility and care plan interventions and wound treatments were not completed as ordered. -Resident #4's pressure ulcers were not assessed by a qualified individual, and the treatment was not /completed as ordered. -Residents #12's and #100's pressure ulcers were not assessed by a qualified individual.This resulted in Substandard Quality of Care for residents with pressure ulcers.Findings include: The New York State Education Department, Consumer Information for Licensed Practical Nurses documents, New York State law does not allow licensed practical nurses to: practice nursing independently, perform nursing assessments or triage, or develop nursing care plans. Licensed practical nurses are not allowed to provide clinical services that require nursing or medical assessments. The facility policy Skin and Pressure Injury Prevention, revised 06/27/2024, documented the facility will assess residents for risk in development of pressure injuries and implement preventative measures in accordance with current standards of practice. The Risk Assessment included assessment of the resident's skin on admission/readmission for existing pressure/injury risk factors utilizing the Braden Risk Assessment, a comprehensive skin assessment upon admission/readmission, weekly skin monitoring by the licensed nurse and staff to inspect the skin when performing personal care. The facility policy Wound Identification and Wound Rounds, revised 11/06/2023, documented the facility will identify, assess, and manage residents with pressure injuries in accordance with current standards of practice. For a newly identified pressure injury the registered nurse completes a skin assessment including documentation of size, depth, stage if applicable, licensed nurse will obtain treatment order and the Wound Nurse/Designee are notified and resident scheduled for weekly wound rounds. For a new wound identified in-house the licensed nurse will perform weekly and as needed skin monitoring and describe their findings in the Electronic Medical Record. The licensed nurse will notify the registered nurse who will complete an Initial Wound Assessment including shape, size, depth, staging and peri-wound. The resident is scheduled for weekly wound rounds. Any wound identified as worsening defined by increase in pain, drainage, necrotic tissue or odor will be assessed by a registered nurse. 1)Resident #8 had diagnoses including stroke, diabetes, and a Stage 4 pressure ulcer on the sacrum. The 04/20/2026, Minimum Data Set (resident assessment) documented the resident had severely impaired cognition; was dependent for most activities of daily living including toileting and bed mobility; was at risk for pressure ulcer development; had a Stage 4 unhealed pressure ulcer; skin and pressure ulcer treatments included pressure reducing device for chair and bed, nutritional/hydration (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	intervention, pressure ulcer care and application of ointments/medications. The 03/28/2026, comprehensive care plan documented the resident was at risk for pressure ulcer development and had actual pressure injury as evidence by Stage 4 on the sacrum, one Stage 3 (full thickness tissue loss) and two (2) unstageable (full thickness tissue loss in which the base of the ulcer is covered by dead tissue) pressure ulcers on the left foot, one unstageable on the right foot, and one unstageable on the left lower leg. Interventions included apply treatment per order, monitor/document report to physician any changes in skin and refer to wound care specialist as needed, turn and reposition every 2-3 hours as indicated, offload heels with pillows and air mattress. The 03/25/2026 readmission Evaluation completed by Registered Nurse #71 documented the resident had the following skin alterations: -Unstageable to the right toe (which toe not identified) measuring 1.8 centimeters x 0.4 centimeters with 100% eschar (black/brownish dead tissue) to the wound bed. -Unstageable to the left toe (which toe not identified) measuring1.3 centimeters x 1.0 with 100% eschar to the wound bed. -Unstageable to the right outer foot measuring 2.3 centimeters x 0.5 centimeters with the wound bed containing 10% granulation tissue (healing tissue) and 90% slough (yellow/whitish dead tissue). -Unstageable to left inner foot measuring 1.8 x 0.8 centimeters, with 100% eschar to the wound bed. -Unstageable to outer left foot measuring 2.8 centimeters x 1.4 centimeters, with 100% eschar to the wound bed. -Unstageable to the left heel, measuring 1.5 centimeters x 1.5 centimeters, with 100% eschar to the wound bed. -Unstageable on the left heel, measuring 1.0 centimeters by 1.0 centimeters and 100% eschar. -Stage 4 pressure ulcer on the sacrum measuring 13.0 centimeters x 20.0 centimeters (no depth documented). The wound had tunnelled (passageways beneath the skin, extending into deeper tissues like muscle or fat) and undermining (a pocket beneath the visible wound margin) had slough granulation yellow green exudate unable to visualize wound bed. On 04/01/2026, Licensed Practical Nurse #11 completed a Weekly Wound Evaluation and the documented the following: -Unstageable pressure ulcer to the [NAME] outer foot measuring 1.4 centimeters x 1.5 centimeters x 0.1 centimeters. The wound bed contained 100% slough. -Unstageable pressure ulcer left inner foot measuring 1.0 centimeter x 0.7 centimeters x 0.1 centimeters. The wound bed contained 100% slough. -Unstageable pressure ulcer to the left outer foot, measuring 0.9 centimeters x 0.5 centimeters x 0.1 centimeters and the wound bed contained 100% slough. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Suspected Deep Tissue Injury (purple/maroon area due to damage of underlying tissue) on the left heel measuring 1.0 centimeter x 0.7 centimeter. -Unstageable pressure ulcer to left inner distal foot, measuring 1.0 centimeter x 1.0 centimeter x 0.1 centimeters. The wound bed contained 100% slough. -Unstageable pressure ulcer to the right inner foot was closed-remains fragile and under observation. -Stage 4 pressure ulcer on the sacrum measuring 10.0 centimeters x 17.0 centimeters x 2.9 centimeters and undermining 2.5 centimeters at 12 o'clock. The wound bed was 50% granulation tissue, 25% slough and 5% eschar. Additional comments included 15% muscle fascia (connective tissue encasing muscle) and 5% bone. The pressure ulcer had improved. There was no documented evidence that the pressure ulcers documented by Licensed Practical Nurse #11 were assessed by a qualified person. There was no evidence of any follow up regarding the pressure ulcer areas noted on the resident's right and left toes, and the two pressure ulcers on the left heel noted by Registered Nurse #71 on 03/25/2026. There was no documented evidence the additional pressure ulcers documented on the resident's right and left inner feet and the suspected deep tissue injury on the left heel were assessed by a qualified person. The 04/06/2026, Physician Assistant #72 progress note documented during physical exam the resident's skin did not have any rashes or lesions noted. On 04/08/2026, Licensed Practical Nurse #10 completed a Weekly Wound Evaluation and documented the following: -Unstageable pressure ulcer on the right outer foot, measuring 1.8 centimeters x 1.0 centimeters x 0.1 centimeters. The wound bed contained 90% granulation tissue and 10% slough. -Unstageable pressure ulcer on the left inner foot measuring 0.8 centimeters x 0.8 centimeters x 0.1 centimeters. The wound bed contained 90% granulation tissue and 10% slough. -Unstageable pressure ulcer left outer foot measuring 0.3 centimeters x 0.3 centimeters x 0.1 centimeters. The wound bed contained 100% slough. -Suspected deep tissue injury on the left heel and the wound status was healed/resolved. -Stage 4 pressure ulcer on the sacrum measuring 10.0 centimeters x 18.0 centimeters x 1.2 centimeters and undermining 2.2 centimeters at 12 o'clock. The wound bed contained 50% granulation tissue, 25% slough, and 5% eschar. -Unstageable pressure ulcer left outer foot measuring 0.3 centimeters x 0.3 centimeters x 0.1 centimeters. The wound bed contained 100% slough. -Unstageable pressure ulcer left inner distal foot measuring 1.5 centimeters x 2.0 centimeters x 0.1 centimeters. The wound bed contained 80 % granulation tissue, 20% slough. There was no documented evidence the pressure ulcers documented by Licensed Practical Nurse #10 were assessed by a qualified person. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/29/2026 at 12:50 PM, Licensed Practical Nurse #11 stated often when they completed dressing changes, dressings were not changed as ordered. Dressing changes were ordered to promote healing of the wound and when treatments were not completed as ordered, wound healing could be impacted. During an interview on 04/30/2026 at 11:43 AM, Licensed Practical Nurse #11 stated they did not complete wound assessments, only evaluated the wounds by collecting data. They documented if the wound was stable or improving, however when the wound was declining, they notified a registered nurse. Most residents were seen weekly by a wound care physician; however, the facility was without a wound physician for about six weeks. They expected the new wound care physician to start this week. During a wound care observation and interview on 05/01/2026 at 12:02 PM, Wound Care Physician #38 stated they assessed and monitored wounds weekly and made recommendations based on their assessment. When they were not in the facility, the nurse assigned to the resident was responsible for completing wound treatment as ordered. During an interview on 05/01/2026 at 11:09 AM, Licensed Practical Nurse #11 stated they completed Resident #8's Braden assessment on 04/09/2026, and the resident was at a high risk with a score of 12. The resident was admitted with multiple extensive pressure wounds. When they noticed the wounds getting worse or if they appeared infected, they would have the nurse practitioner, or a registered nurse assess the wounds right away. 2) Resident #209 had diagnoses including multiple sclerosis (progressive neurological disease) and infection of the left heel pressure ulcer. The 04/01/2026 Minimum Data Set documented the resident had intact cognition, required moderate assistance for personal care and bed mobility, had a chronic urinary drainage tube and was frequently incontinent of stool. The resident was at risk for pressure ulcer development; had Stage 3 and Stage 4 unhealed pressure ulcers; skin and pressure ulcer treatments included pressure reducing devices for chair and bed, turning/repositioning program, nutritional/hydration intervention, and pressure ulcer care. The 10/22/2025, comprehensive care plan documented the resident was at risk for and had alteration in skin integrity as evidence by a Stage 3 on the left heel and Stage 4 on the left inner ankle. Interventions included, off load heels with pillow or boots as tolerated, weekly assessment of wound by licensed nurse or provider, including length, width, depth, tissue type, drainage, odor, pain and signs/symptoms of infection. On 01/05/2026, the care plan was updated to include apply treatment per order, avoid clothing/devices/footwear that may impede healing and communicate status of wound to resident or representative. The 04/20/20206, Admission/readmission Evaluation Part One completed by Licensed Practical Nurse Unit Manager #5 documented the resident had a pressure injury on the left outer ankle. There was no further description of the wound or additional skin impairments noted. On 04/21/2026, a Weekly Wound Evaluation completed by Licensed Practical Nurse #11 documented the following: -The resident was not seen by the wound care provider. -Stage 3 pressure ulcer on the left heel, measuring 0.8 centimeters x 1.0 centimeters and the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	description of the wound was dry scab. -Stage 4 pressure ulcer on the left inner ankle, measuring 5.0 centimeters x 5.5 centimeters x 0.1 centimeters and the wound bed contained 100% granulation tissue. There was no documented evidence the pressure ulcers were assessed by a qualified person and there was no documentation related to the pressure ulcer noted on the left outer ankle by Licensed Practical Nurse Unit Manager #5 on 04/20/2026. The 04/21/2026, physician orders included cleanser left inner ankle with wound cleanser, apply collagen and alginate AG to wound bed and cover with absorbent pad, every evening shift and as needed if dressing was soiled or displaced. Cleanse left heel with wound cleanser and leave open to air every evening. During an observation and interview on 04/27/2026 at 9:32 AM, Resident #209 was in bed with their left heel resting directly on the mattress. The left inner ankle had a dressing dated 04/25/2026. Resident #209 stated their dressing was last changed on 04/25/2026 at approximately 4:30 PM by Licensed Practical Nurse #12 who also worked 04/26/2026 on the evening and overnight shift. They asked Licensed Practical Nurse #12 if they could change the dressing and they said they were too busy to change the dressing. The April Medication Administration Record documented the treatment to the resident's left inner ankle was completed on the evening shift of 04/25/2026 and 04/26/2027 by Licensed Practical Nurse #12. During an interview on 4/30/2026 at 11:43 AM, Licensed Practical Nurse #11 stated they would not assess the resident's wound. They collected the data if the wound was stable or improving. If the wound was declining, they must inform the registered nurse on the wound team or whatever registered nurse they could find to assess the wound. They stated the facility had not had a wound physician for six weeks. During an interview on 04/30/2026 at 2:40 PM, Licensed Practical Nurse #12 stated most dressing changes were done on the day shift, by the wound team, but if the wound team did not do the dressing, they completed the dressing change. They signed off on all their resident dressing and treatments at the beginning of their shift, and if a resident refused the treatment they went back in the record and documented an addendum progress note. They stated they may have put the wrong date on the resident's dressing on 04/26/2026. The resident was alert and oriented and if they said the dressing was not done, then it was not done. They stated sometimes it was very busy, and they had to prioritize what needed to be done. During a follow-up interview on 05/01/2026 at 11:09 AM, Licensed Practical Nurse #11 stated Resident #209's last Braden assessment was completed on 03/01/2026 and the resident was considered a moderate risk meaning the resident was still at risk and predisposed to pressure ulcers. 3) Resident #4 had diagnoses including venous insufficiency (poor circulation), lymphedema (fluid buildup), and muscle weakness. The 04/01/2026 Minimum Data Set documented the resident had intact cognition, was independent for most activities of daily living, was at risk of developing pressure ulcers, had Stage 2 and Stage 4 unhealed pressure ulcers, had pressure reducing devices for the chair and bed, was on a turning and repositioning program, had nutrition/hydration interventions, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pressure ulcer care and application of nonsurgical dressings. The12/08/2024 comprehensive care plan documented the resident was at risk of developing pressure ulcers related to impaired mobility. Interventions included gel/foam cushion for wheelchair and offload heels with pillows or boots. On 02/01/2026, the comprehensive care plan was updated to reflect the resident had an actual Stage 4 pressure ulcer on the left heel and left outer shin. Interventions included to apply treatment per order and evaluate the wound weekly and as needed. The 03/11/2026, Wound Physician Consultation note documented the resident had a Stage 4 pressure ulcer on the left heel, measuring 2.5 centimeters x 2.0 centimeters x0.2 centimeters. The wound bed contained 90% granulation tissue and 10% slough. The resident also had a Stage 4 pressure ulcer to left outer shin, measuring 4.0 centimeters x 2.0 centimeters x 0.4 centimeters. The wound bed contained 70% granulation tissue and 30% slough with undermining of 0.5 centimeters at 1 o'clock. Both pressure ulcers were debrided to remove necrotic tissue and establish margins of viable tissue. There was no further documentation from the Wound Physician Consultant. The following Weekly Wound Observations were completed by a licensed practical nurse: -On 03/18/2026 the left heel Stage 4 measured 2.0 centimeters x 1.8 centimeters x 0.2 centimeters and the wound bed contained 90% granulation tissue and 10% slough. The left outer shin Stage 4 measured 3.7 centimeters x 1.8 centimeters x 0.3 centimeters and there was no description of the wound bed. There was no documentation related to the undermining noted by the Wound Physician on 03/11/2026. -On 03/25/2026 the left heel Stage 4 measured 0.8 centimeters X 0.8 centimeters and the wound bed contained 80% granulation tissue and 20% slough. The left outer shin Stage 4 measured 2.5 centimeters x 1.2 centimeters x 0.2 centimeters. The wound bed contained 40% new skin growth, 40% granulation tissue and 20% slough. -On 04/01/2026 the left heel Stage 4 measured 0.6 centimeters x 0.6 centimeters x 0.1 centimeters and the wound bed contained 90% granulation tissue and 10% slough. The left outer shin Stage 4 measured 2.8 centimeters x 1.0 centimeters x 0.2 centimeters and the wound bed contained 95% granulation tissue and 5% slough. -04/06/2026 the left heel Stage 4 measured 0.5 centimeters by 0.5 centimeters x 0.1 centimeters and the wound bed contained 90% granulation tissue and 10% slough. The left outer shin Stage 4 measured 2.5 centimeters x 1.2 centimeters x 0.1 centimeters and the wound bed contained 95% granulation tissue and 5% slough. -04/13/2026 the left heel Stage 4 measured 0.4 centimeters x 0.5 centimeters x 0.1 centimeters and the wound bed contained 95% granulation tissue and 5% slough. The left outer shin Stage 4 measured 2.6 centimeters x 1.5 centimeters x 0.1 centimeters and the wound bed contained 95% granulation tissue and 5% slough. -04/23/2026 the left heel Stage 4 measured 0.3 centimeters x 0.3 centimeters x 0.1 centimeters and the wound bed contained 100% granulation tissue. The left outer shin Stage 4 measured 2.2 centimeters x 1.8 centimeters x 0.1 centimeters and the wound bed contained 100% granulation tissue. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was no documented evidence from 03/11/2026-04/23/2026 the resident's pressure ulcer was assessed by a qualified individual. The April 2026 Treatment Administration Record documented the dressing to the resident's left outer shin was not done and Other/See Nurses Note. There was no documented evidence indicating why the dressing to the left outer shin was not changed on 04/28/2026. During an observation on 04/29/2026 at 5:44 AM the resident's left leg was resting on a pillow with a dressing dated 04/27/2026. During an observation and interview on 04/29/2026 at 12:50 PM Licensed Practical Nurse #11 stated the dressing had the date 04/27/2026, which indicated the dressing was not changed on 04/28/2026. It should have been changed as the resident never refused wound care. They stated that many times when they completed rounds with the wound care team, they found dressings were not being changed as ordered. Provider orders should be followed and the dressings done as they were ordered. During an interview on 04/30/2026 at 2:40 PM, Licensed Practical Nurse #12 stated they signed off they completed Resident #4's dressing but they did not complete it. They were unable to complete the dressing change to the wound because the resident was not in bed, and it was on the foot. They stated when the resident was in bed, they refused to have the dressing changed. They did not write a progress note or notify the supervisor. During an interview on 05/01/2026 at 11:09 AM, Licensed Practical Nurse #11 stated the resident's Braden score was a 12 on 03/07/2026 and meaning the resident was a high risk and predisposed to develop pressure injury. If a resident was high risk they would encourage repositions, elevate heels, and use lotions. As the licensed practical nurse, they did not initiate care plan goals/ or focus areas but would make recommendations for interventions. During an interview on 05/01/2026 at 12:23 PM, Licensed Practical Nurse #9 stated they were part of the wound team along with Licensed Practical Nurse #10 and Registered Nurse #13. They recently had a new wound care provider start. Occasionally a provider or registered nurse would sign off on their notes. If a wound was healing or resolved they updated a registered nurse, however, they were not always able to find a registered nurse. They probably should not have documented a wound as healed or resolved, as that was an assessment. The wound team rounded together and wrote down the measurements and assessments on paper then split up the residents and documented them in the electronic medical record. It was possible to document data that was completed by someone else. During an interview on 05/01/2026 at 1:19 PM, Licensed Practical Nurse #10 stated they documented that Resident #13's wound healed and resolved. They did not tell a registered nurse since the wound team registered nurse was not available. They should not have assessed and documented the wound as resolved; the registered nurse should have assessed the wound and resolved it. During an interview on 05/01/2026 at 1:46 PM, Assistant Director of Nursing #3 stated the Braden Risk Assessment was reviewed by registered nurses. The licensed practical nurse would start the Braden Risk Assessment, but a registered nurse finished the assessment and signed it. Licensed practical nurses should not document whether a wound was healed or resolved. The registered nurse needed to assess the wound and write a note. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/01/2026 at 2:06 PM, Registered Nurse #13 stated they were part of the wound team and had not received specific training on wounds. They performed and documented the initial wound assessments. They were unsure what a licensed practical nurse could document versus what was considered an assessment. The licensed practical nurse informed a registered nurse if the wound was worsening. A registered nurse or wound provider should assess the wound and document. During an interview on 05/05/2026 at 12:07 PM, the Administrator stated they had a wound team that consisted of Registered Nurse #13, Licensed Practical Nurse #9 and Licensed Practical Nurse #10. They did not know how often the wound team rounded. They did not know the scope of practice for licensed practical nurses or registered nurses. During a follow-up interview on 05/05/2026 at 12:25 PM, Nurse Consultant #69 stated licensed practical nurses were able to follow and evaluate the wound since an initial assessment was completed by a registered nurse and the registered nurse and provider accompanied them on wound rounds. There was a gap in time when there was no provider present in the facility during the evaluation. 10 New York Codes, Rules and Regulations 415.12(c)(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews, the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for two (2) of two (2) test trays (04/28/2026 lunch and 04/29/2026 breakfast); and 12 of 17 anonymous residents present at the Resident Council meeting and two (2) of two (2) residents (Residents #346 and #20) interviewed. Specifically, the 04/28/2026 lunch tray and the 04/29/2026 breakfast tray included hot foods served below 140 degrees Fahrenheit and cold foods served above 41 degrees Fahrenheit and were not palatable; 12 anonymous residents at the Resident Council meeting stated the food was cold and overcooked; and Residents #346 and #20 stated the food was not palatable.Findings include: The facility policy Food Temperatures, dated 5/28/2025, documented hot food would be served at no less than 140 degrees Fahrenheit and cold food would be served no higher than 41 degrees Fahrenheit. Appropriate food transport equipment to maintain safe temperatures would be utilized. During an interview on 04/27/2026 at 11:05 AM, Resident #346 stated the food was not good. During an interview on 04/27/2026 at 1:21 PM, Resident #20 stated they did not always get what they preferred on their meal trays and the food was cold at times. During a Resident Council meeting with surveyors on 04/27/2026 at 2:00 PM, 12 anonymous residents stated the food was not palatable, was cold at times, at times the meat was too tough to eat or to cut with plastic utensils, and food was sometimes inconsistent with their meal tickets. During a meal observation on 04/27/2026 at 1:31 PM, the meal tray cart arrived on Unit C south. There were six (6) trays not in the cart and four (4) on the cart did not have their lid tight. The first tray was passed at 1:42 PM. At 1:44 PM, the tray cart door remained open. At 1:57 PM, there were two (2) trays remaining within the open-door cart. Those trays remained as they were refused by their respective residents. During an observation on 04/28/2026 at 1:47 PM, Resident #270's meal was used as a test tray with the resident's permission, and a replacement was ordered. The following food temperatures were verified with Certified Nurse Aide #30: -4-ounce turkey meatloaf was 128.7 degrees Fahrenheit. -1/2 cup garden rice was 135.1 degrees Fahrenheit and tasted bland. -1/2 cup yellow squash was 135 degrees Fahrenheit and was mushy in consistency; and -4-ounce milk was 55.2 degrees Fahrenheit. During an interview on 04/28/2026 at 2:31 PM, Certified Nurse Aide #30 stated many residents complained the food was late, the food was cold, and Unit C was usually the last floor served. Certified Nurse Aide #30 pointed out a sign documenting unit breakfast service was at 9:30 AM and lunch service was at 1:20 PM. The aide stated the food looked unappetizing. During an observation on 04/29/2026 at 9:50 AM, Resident #270's breakfast tray was used as a test tray, and a replacement was ordered. The following food temperatures were verified with Certified Nurse Aide #30: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Milk was 51.4 degrees Fahrenheit. -Apple Juice was 53.2 degrees Fahrenheit. - Biscuit with 2 ounces of sausage gravy was 117 degrees Fahrenheit and tasted cool and the biscuit was hard to chew; and -Oatmeal 6 ounces was 147.7 degrees Fahrenheit and tasted bland. During an interview on 04/29/2026 at 12:12 PM, Licensed Practical Nurse #25 stated there were many residents who complained about the food being cold, small portions, and it did not taste good. Residents also complained they did not get what they wanted. When that happened, a sandwich or substitute was offered, and the kitchen was notified. During an interview on 05/01/2026 at 12:05 PM, Dietary Supervisor #51 stated the cold production side of the tray line handled all cold products. Every resident had a meal ticket that was placed on the tray to ensure the resident received the appropriate food and drink items. Plates were kept in a hot box prior to use and were covered with a lid once plated. The tray went down the tray line with hot foods plated first and cold food/drink items paced last before each tray went on the food cart to be delivered to the unit. The loader was the last staff member to ensure accuracy of the tray. It took about 10 minutes to complete each unit's tray service and cart load and then the cart went immediately to the designated unit. Alternates were available. Food temperatures were checked on the tray line numerous times by the cook. Hot foods should be above 140 degrees Fahrenheit and cold foods should be less than 41 degrees Fahrenheit when delivered to the residents. During an interview on 04/30/2026 at 12:26 PM, Licensed Practical Nurse Manager #5 stated multiple residents complained the food received was not what they wanted, was cold, or that it was late. They stated they contacted the kitchen for a replacement or for missing food items, and unit staff did the same for food related concerns. Food should be hot and tasty. 10 New York Codes, Rules, and Regulations 415.14(d)(1)(2)