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	05/12/2026

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on record review and interviews (#2994892) the facility failed to ensure intravenous fluids (fluids that were administered directly into a vein) were administered consistent with professional standards of practice and in accordance with physician orders. This was identified for one (1) of two (2) residents (Resident #1), reviewed for hydration and receiving intravenous therapy. Specifically, Resident #1 had an order for fluids via intravenous route, the fluids were not provided as ordered, and the resident received 1000 cubic centimeters all at once, instead of over time. Nursing staff did not monitor the rate of the fluid infusion. The physician telephone order was not transcribed as an order and was not included on the Medication Administration Record and was not documented as administered. A facility investigation was completed on whether the correct fluid was administered but did not address these concerns.Findings include:The facility's Intravenous Infusion Therapy policy, last reviewed April 2026, documented the physician's order for intravenous therapy must be verified with the medication bag/bottle. Nursing staff were to document medication, flushing agent, date, time, and the nurse administering on the medication administration record. The date, time, and resident response was to be documented on the appropriate nursing documentation. Resident #1 had diagnoses of hemiplegia (one sided weakness) affecting right dominant side following a cerebral infarction (stroke), dementia, and hypertension (high blood pressure). The 04/20/2026 Minimum Data Set assessment documented Resident #1 had intact cognition. The resident received antipsychotic, anti-anxiety, antidepressant, anticoagulant (prevents blood clots), diuretic and hypoglycemic (such as insulin) medications daily.The 11/16/2022 Comprehensive Care Plan Report documented the resident had actual/potential fluid deficient due to diuretic use (medications used to eliminate excess salt and water from the body). Interventions included monitoring laboratory results and medications as ordered by the physician, promoting additional fluid intake, monitoring vital signs, and reporting abnormalities.The 04/22/2026 general progress note by Primary Physician #10 documented Resident #1 was seen for increased somnolence (drowsiness) and unsteady gait. Their blood sugars were running higher, and the resident had been exhibiting signs of increased anxiety and depression. At that time, psychotropic medications were being cross tapered (switching one medication to another). The physician was to have the nurse manager order a complete blood count (blood test) and urinalysis to rule out infection and to monitor the resident's blood sugars. There were no other documented medical provider or nursing progress notes from 04/22/2026 through 04/25/2026 related to the resident's change in condition or orders for intravenous fluids. The 04/26/2026 at 12:12 AM nursing assessment progress note entered by Registered Nurse Supervisor #5 documented the following: 24 gauge (needle size) intravenous started to the resident's left forearm with immediate blood return and no discomfort. Normal saline 500 cubic centimeters bolus was initiated, after which the rate will be decreased to 100 cubic centimeters an hour for two days. The resident also received Rocephin (antibiotic) 1 gram intermuscular (injection into the muscle tissue) and then intravenous for seven days, with blood work, urinalysis and chest x-ray to follow. The 04/01/2026 through 04/26/2026 Order Summery Report did not contain the order for the intravenous therapy infusion of normal saline that was administered to the resident on 04/26/2026.The April 2026 Medication and Treatment Administration Records did not include the intravenous therapy infusion of normal saline.The 04/26/2026 facility internal (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation completed by the Administrator was initiated due to an accusation made by Registered Nurse Supervisor #6 that Registered Nurse Supervisor #5 administrated the wrong infusion of dextrose solution (sugar and water) instead of the normal saline to Resident #1. The investigation concluded this accusation was unfounded, and the resident received the correct intravenous infusion. A picture of the intravenous bag was obtained with a label that stated one liter of normal saline fluid was hung on 04/25/2026 at 10:50 PM, 500 cubic centimeters bolus then decrease rate. Statements included Registered Nurse Supervisor #6, who documented it was their mistake they read the bag wrong. Resident #1 was unresponsive and received the entire bag of intravenous fluid, as the bag and tubing were empty. The order was for 500 cubic centimeters bolus and not the entire bag. Registered Nurse Supervisor #5 did not stay with the resident to watch the amount of fluid given. The tubing was left wide open (tubing not clamped to adjust the flow rate, allowing for fluid for flow as fast as gravity and the size of the catheter allow) and the bag emptied.The 04/26/2026 facility investigation did not address the error in the intravenous infusion, or the lack of documentation and physician orders. During an interview on 05/11/2026 at 12:30 PM the Administrator stated the Director of Nursing was out on extended sick leave and a nurse consultant was filling in, although the nurse consultant was not involved in the investigation on 04/26/2026. The Administrator stated due to not being a nurse, they did not address the errors with the administration of the intravenous fluid including: infusing all at once instead of the 500 cubic centimeters bolus and then 100 cubic centimeters an hour; the telephone order not transcribed and not placed in the Medication Administration Record as given; and the empty intravenous bag still attached to the resident with the tubing open.During a phone interview on 05/12/2026 at 12:13 PM Registered Nurse Supervisor #5 stated on 04/26/2026 they were mainly concerned about the accusation Registered Nurse Supervisor #6 made that they gave Resident #1 dextrose instead of normal saline. After initiating the intravenous therapy, they went back to the supervisor's office because it was change of shift. They told Licensed Practical Nurse #8 to monitor the infusion because they left the tubing wide open and when the fluid went down to 500 cubic centimeters, the drip needed to be turned down. This was also told to the oncoming nurse, Registered Nurse Supervisor #6, plus the instructions were on the bag. Registered Nurse Supervisor #6 left and then returned to the supervisor's office upset. They did not speak about all the fluid being infused at once. They were concerned about the possibility of dextrose being given instead of the normal saline. During a phone interview on 05/12/2026 at 12:36 PM, Licensed Practical Nurse #8 stated they worked the 3:00 PM to 11:00 PM shift on 04/25/2026. A certified nursing assistant came to them and said that Resident #1 was in bed and did not appear well. Registered Nurse Supervisor #5 was notified, called the on-call medical provider, and obtained an order to start intravenous therapy. The licensed practical nurse and the certified nursing assistant sat with the resident, and they were still there after midnight. A licensed practical nurse can monitor the infusion site for any reaction, but a registered nurse starts the infusion and adjusts the drop flow (rate). Licensed Practical Nurse #8 did not touch the bag or tubing and told the oncoming nurse, Licensed Practical Nurse #12 about the resident.During a phone interview on 05/12/2026 at 1:23 PM Registered Nurse Supervisor #6 stated (on 04/26/2026, when they accused Registered Nurse Supervisor #5 of using the wrong fluid) they misread the bag as dextrose, and apologized for their error. They were told by Registered Nurse Supervisor #5 the infusion was to run as a 500 cubic centimeters bolus and then 100 cubic centimeters every hour. The fluid bag started at approximately11:00 PM, and Registered Nurse Supervisor #5 did not stay and monitor it because they were busy with other residents who had falls. During a phone interview on 05/12/2026 at 4:41 PM Certified Nursing Assistant #9 stated on the evening shift of 04/25/2026, they asked Registered Nurse Supervisor #5 to look at the resident who was sweating. The resident's blood sugar was high and an intravenous line was placed in their arm. Their shift was over (at 11:00 PM), but they stayed in the resident's room. There was fluid left in the bag and the resident was lying there sleeping. During a phone interview on 05/12/2026 at 5:05 PM Licensed Practical Nurse #12 stated they worked the11:00 PM to 7:00 AM shift on 04/26/2026. They (continued on next page)

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