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	12/20/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48446 Based on observations, record review, and interviews during the recertification and abbreviated (NY00357875) surveys conducted 12/16/2024-12/20/2024, the facility did not ensure residents had the right to a dignified existence in a manner and an environment that promoted the maintenance or enhancement of quality of life for 1 of 3 residents (Resident #110) reviewed. Specifically, Resident #110 was unshaven and had visible chin and lip hair. Findings include: The facility policy, Activities of Daily Living Care and Support, revised 3/13/2024, documented each resident was provided activities of daily living care and support in accordance with current standards of practice, State and Federal regulations and were based on the resident's needs, personal preferences, and goals. Facial hair was groomed according to the resident preference and/or assessed needs. The facility policy, Quality of Life/Dignity, revised 5/28/2024, documented residents were cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. Residents were groomed as they wished to be groomed including hair, nails, and facial hair. Resident #110 had diagnoses including anxiety disorder, major depressive disorder, and dementia. The 10/4/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, did not reject care, and required partial to moderate assistance for most activities of daily living. The Comprehensive Care Plan updated 10/4/2024 documented the resident required assistance with self-care related to dementia and impaired mobility. Interventions included encouraging the resident to participate in their care. The resident care instructions documented Resident #110 was showered on Thursdays during the 7:00 AM-3:00 PM shift, required substantial assistance of one staff for personal hygiene. During observations on 12/16/2024 at 3:24 PM and on 12/17/2024 at 9:26 AM and 11:48 AM, Resident #110 had hair on the right side of their chin, and several hairs on their upper lip. (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

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 12/20/2024
NAME OF PROVIDER OR SUPPLIER: Bishop Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 918 James Street Syracuse, NY 13203	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Documentation Survey Report (activities of daily living tasks completed by certified nurse aides) documented Resident #110 received a shower on 12/5/2024 during the 3:00 PM-11:00 PM shift and on 12/19/2024 during the 7:00 AM-3:00 PM shift. The 12/12/2024 showering task was blank, indicating a shower was not provided. During an interview on 12/19/2024 at 10:58 AM, Resident #110 stated they had received a shower that day, but they were not shaved and wanted to be shaved. The resident had visible hair on their chin and upper lip. During interviews on 12/16/2024 at 3:24 PM and on 12/17/2024 at 11:48 AM, Resident #110's family member stated they normally shaved Resident #110 as the resident did not like to have facial hair. They recently moved out of the area and was not able to shave the resident. They expected staff to assist the resident with removal of facial hair. During an interview on 12/19/2024 at 11:19 AM, Certified Nurse Aide #15 stated they were responsible for providing care to residents which included shaving. Residents were shaved on their shower day or when they required a shave that did not coincide with their shower day. Resident #110 was reliable if they said they wanted to be shaved. They were showered earlier but was not shaved as the lighting in the shower was poor. Certified Nurse Aide #15 stated, if a resident wanted to be shaved and was not shaved it might make the resident feel sad, embarrassed, and depressed. During an interview on 12/19/2024 at 11:28 AM, Licensed Practical Nurse #16 stated certified nurse aides were responsible for shaving residents and should ask residents if they would like to be shaved when facial hair was noticed. If a resident wanted to be shaved and was not it might make them feel unpresentable. During an interview on 12/20/2024 at 8:54 AM, Registered Nurse Unit Manager #17 stated certified nurse aides were responsible for completing activities of daily living for residents who were unable to complete them independently. Shaving was included in activities of daily living and was completed with showers. Family and residents should not have to ask staff to be shaved. If a resident was not shaved it might make them feel less confident. When they noticed lip and chin hair on a female resident, they asked the certified nurse aide to shave the resident. During an interview on 12/20/2024 at 11:11 AM, Assistant Director of Nursing #9 stated it was the certified nurse aide's responsibility to shave residents. They expected residents that wanted to be shaved to be shaved. If a resident wanted to be shaved and were not, it was a dignity issue. 10 NYCRR 415.5(b)(1-3)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 48895 Based on observations, record review, and interviews during the recertification survey conducted 12/16/2024-12/20/2024, the facility did not ensure resident rights to privacy and confidentiality of their personal and medical records for 14 of 29 residents on the 2 North Unit. Specifically, the Narcotics Logbook (a logbook with resident names and narcotic administration information) with confidential information for 14 residents on the 2 North unit was left unsecured in a resident's room with a resident present. The facility policy, Resident Rights, revised 5/28/2024, documented residents had the right to privacy and confidentiality. During an observation on 12/16/2024 at 10:39 AM, Licensed Practical Nurse #18 left the Narcotic Logbook on the dresser in Resident #17's room. The resident was in the room. During an observation on 12/16/2024 at 1:09 PM, the Narcotic Logbook remained on the dresser in Resident #17's room. The logbook documented the names of 14 residents and their room number; the narcotic medications they were prescribed; and the corresponding diagnoses for the medication. During an interview on 12/18/2024 at 1:14 PM, Licensed Practical Nurse #18 stated the narcotic book was kept locked in the medication cart or locked in the medication room for confidentiality reasons. They stated they left the Narcotic Logbook in Resident #17's room earlier in the week for several hours due to being distracted with an incident on the unit. They stated they left the book in the room prior to the resident going to an appointment. They should not have left the logbook in the resident's room as this was a violation of resident confidentiality. Resident #17 was a cognitively intact resident. During an interview on 12/19/2024 at 11:07 AM, Registered Nurse Unit Manager #17 stated the Narcotic Logbook was locked in either the medication room or the medication cart when it was not being used and should never be left in a resident room as it contained personal resident information. During an interview on 12/20/2024 at 11:11 AM, Assistant Director of Nursing #9 stated the narcotic logbooks were kept in the medication cart or in the medication room for security and confidentiality. The logbook should never be left in a resident room as information could be altered. 10NYCRR 415.3(d)(1)(ii)

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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. 48052 Based on observations, record review, and interviews during the recertification and abbreviated (NY00362924) surveys conducted 12/16/2024-12/20/2024, the facility did not ensure residents had the right to a safe, clean, comfortable, and homelike environment for 1 of 4 residents (Resident #29) reviewed. Specifically, Resident #29's room had black, and gray build up approximately 1 to 3 inches from the base of the wall near the entrance of the room, extending to the two-drawer dresser. Findings include: The facility policy, Home Like Environment, dated 9/19/2022, documented residents would be provided with a safe, clean, comfortable, and homelike environment. The staff shall maximize, to the extent possible, cleanliness and order. The 5-Step Daily Room Cleaning guidelines, last reviewed 12/15/2022, documented the housekeeping staff were to dust mop the entire floor which included all corners and along all baseboards to prevent build up. Housekeepers were to damp mop after dry mopping. The most important area to disinfect was the resident's floor as most air-borne bacteria would settle so the floors needed to be disinfected daily. As with the dust mopping, the housekeeping staff was to move all furniture necessary and run the mop along the edges first. The following observations were made of the floor in Resident #29's room: - during observation and immediate interview on 12/17/2024 at 9:08 AM, Resident #29 stated they did not feel the housekeeping staff did a thorough cleaning job. They stated there was a dirt shadow around the bottom molding of the wall and they did not like it. There was a dark halo of buildup visible around the bottom rubber molding of the wall, from the door extending to the two-drawer small dresser. - on 12/18/2024 at 9:24 AM, the wall next to the door and around the trash can was visibly gray, dusty, and had dirt build up about 2-3 inches from the bottom of the rubber wall barrier. - on 12/19/2024 at 9:14 AM, there was a line of grime/greyish black buildup of dirt extending 1-3 inches from various areas of the baseboard along the wall where the door rests and between the wall protrusion extending to the two-drawer small dresser. - on 12/20/2024 at 8:41 AM, the floor had grime/dirt build up that was dark and light gray around the baseboard of the wall extending 1-3 inches from various areas of the baseboard, along the wall from the door to the wall protrusion extending to the two-drawer small dresser. During an interview on 12/20/2024 at 8:46 AM, Light Housekeeper #13 stated they were supposed to clean resident room floors every day including around the baseboard. (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, observation, and record review on 12/20/2024 at 8:50 AM, the Account Manager/Acting Director of Environmental Services stated the housekeepers had a 5-step cleaning task sheet for the resident's room and 7-step cleaning task sheet for the resident's bathroom. The housekeepers were also responsible for one deep cleaning of a resident room a day that was based on a monthly schedule. They only audited the room that was deep cleaned by the housekeeping staff. During the 5-step resident room cleaning, the housekeeper was to dust mop and damp mop the floors. If there was build up along the baseboard, the housekeepers had scrapers and should clean the buildup during their regular daily cleaning. If they were unable to clean the buildup, the housekeepers were to inform them right away so it could be taken care of. They stated per their records the last time Resident #29's room was deep cleaned was on 12/2/2024. At 8:59 AM, the Account Manager/Acting Director of Environmental Services viewed the gray and black buildup extending from the baseboard of Resident #29's wall at the entrance to their room and next to the bathroom door. They stated the buildup should have been cleaned when the room was cleaned daily. This could have been done with a scraper and chemical or by the floor technician if needed. They were unaware of the buildup in the resident's room before now. 10 NYCRR 415.29(b)(j)(1)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49448 Based on record review and interviews during the recertification and abbreviated (NY00351261) surveys conducted 12/16/2024-12/20/2024, the facility did not ensure that prompt efforts were made to resolve grievances for 11 of 11 anonymous residents and for 1 of 1 additional resident (Resident #127) reviewed. Specifically, 11 of 11 residents in attendance at the resident group meeting stated their grievances were not always acted upon timely and they were not provided with an explanation why. Additionally, Resident #127's family member filed 3 grievances and they did not receive prompt resolutions. Findings include: The facility policy, Grievances, revised 7/2/2024, documented the facility assisted residents, resident representatives, family members, or resident advocates in filing a grievance when concerns were expressed. The facility investigated and resolved resident grievances in a timely manner in accordance with current state and federal guidelines. The Director of Social Work was the facility's Grievance Officer and was responsible for facilitating the grievance process. Grievances were completed and documented within 7 business days and the person that filed the grievance received resolution both verbally and in writing. The undated facility Admission Agreement documented residents had the right to voice grievances and to receive prompt resolution. During a resident group meeting on 12/16/2024 at 2:05 PM, 11 of 11 anonymous residents in attendance stated the facility did not respond to grievances promptly and did not provide rationales as to why the responses were not timely. Resident #127 had diagnoses including unspecified dementia and aphasia (difficulty speaking) related to a cerebral infarction (stroke). The 10/16/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition. The 10/11/2021 Health Care Proxy form documented Resident #127's family member was appointed as their health care agent and made any and all health care decisions for them, except to the extent that they stated otherwise. Resident #127's Health Care Proxy filed the following grievances: - on 8/7/2024 regarding concerns of tube feed administration and other various concerns. The Administrator signed the investigation as completed on 8/14/2024. The Director of Social Work notified the resident's representative of the grievance resolution on 11/7/2024 by electronic mail (approximately 3 months after the completion of the investigation). (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 9/23/2024 regarding various medical treatment complaints. The Administrator signed the investigation as completed on 9/30/2024. The Director of Social Work notified the resident's representative of the grievance resolution on 11/27/2024 by electronic mail (approximately 2 months after the completion of the investigation). - on 11/13/2024 regarding concerns related to incontinence care. The Assistant Director of Nursing signed the investigation as completed on 11/13/2024. The Director of Social Work notified the resident's representative of the grievance resolution on 11/26/2024 by electronic mail (approximately 2 weeks after the completion of the investigation). During an interview on 12/19/2024 at 1:37 PM, the Director of Social Work stated grievances were investigated by the appropriate department director. They met with the Administrator weekly and reviewed recent grievances. Residents and/or family members then received follow-up. Resident #127's representative received follow up of grievances via electronic mail and a hard copy was also sent to them via the United States Postal Service. The 8/7/2024, 9/23/2024, and 11/13/2024 grievances for Resident #127 were not followed up timely. The resident's representative was supposed to receive follow up of grievance resolution within 7 days. It was important grievances were followed up and the resident's representative received notification of resolution promptly to address concerns immediately and prevent possible medical issues. During an interview on 12/20/2024 at 8:43 AM, Licensed Practical Nurse Assistant Unit Manager #22 stated Resident #127's representative filed frequent grievances. The grievances were usually initiated by the Administrator. They stated if needed they gathered documents for the investigation and provided education to staff. They completed their part of the investigation timely, usually within 48 to 72 hours and provided that information to Social Worker #23. During a telephone interview on 12/20/2024 at 10:24 AM, the Administrator stated grievances should be followed up immediately. The response should be given to the person filing the grievance within 7-10 days. Resident #127's grievances were filed by their representative and their concerns were addressed timely, but the responses were not provided timely. There was a hiccup in the process. They were working with the Director of Social Work on improving the timeliness of grievance resolution follow up. During a telephone interview on 12/20/2024 at 10:43 AM, Social Worker #23 stated once they received the appropriate grievance documents, they turned them into the Director of Social Work. Everything needed for the investigation was supposed to be given the Director of Social Work within 5-7 days. They usually received the information from Licensed Practical Nurse Assistant Unit Manager #22 in 2-3 days and gave it to the Director of Social Work the same day it was received. The Director of Social Work took care of grievances for Resident #127 directly because they received the electronic communication from them. The Director of Social Work was responsible for ensuring resolution communication was sent to the resident's representative and 2-3 months was not timely. The residents were the most important and grievances should be taken seriously. 10NYCRR 415.13(C)(1)(ii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48895 Based on observations, record review, and interviews during the recertification and abbreviated (NY00351261, NY00351349, NY00362924, and NY00362952) surveys conducted 12/16/2024-12/20/2024, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 2 residents (Resident #127) reviewed. Specifically, Resident #127 did not have their Scopolamine patch (used to treat nausea and vomiting and decrease respiratory secretions) monitored for placement as ordered. Findings include: The facility policy, Medication Administration, dated 12/2019, documented medications were administered as prescribed. Medications were administered in accordance with the orders and included any required time frame. The facility policy, Physician Orders, dated 2/2020 documented that unclear or incomplete written orders would be reviewed with the physician. Any order clarification should be documented. Resident #127 had diagnoses including dementia, and dysphagia (difficulty swallowing) following cerebral infarction (stroke). The 10/16/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, was dependent for oral hygiene, and received nutrition via tube feeding (a tube that delivers nutrition directly into the stomach). The Comprehensive Care Plan initiated 7/19/2022 documented the resident had actual/ potential for aspiration (food or liquid accidentally enters the airway and lungs) related to dysphagia and tube feed. Interventions included signs and symptoms of aspiration such as coughing, and sputum (phlegm) production were monitored. The physician orders documented: - On 2/21/2021 (original order date) Scopolamine patch 72-hour, apply 1.5 milligram transdermal one time a day every 3 days for secretions. On 11/8/2024 cleanse area well and dry. Apply no-sting skin-prep to area, let dry, and then apply. Place behind the ear, alternating each time and remove per schedule. - On 2/25/2023, 3/7/2023, 6/9/2023, 1/8/2024, and 4/10/2024 check placement of scopolamine patch every shift. - On 9/9/2024 suction resident every 4 hours and as needed for excessive secretions. The December 2024 Medication Administration Record documented the Scopolamine patch was placed behind the resident's left ear on 12/14/2024 at 6:00 PM by Licensed Practical Nurse #31. The resident was observed at the following times without the Scopolamine patch in place: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 12/16/2024 at 11:11 AM seated in their wheelchair in the hallway outside of their room, coughing. At 1:04 PM, Licensed Practical Nurse #33 took the resident into their room and said they were going to suction (remove saliva or mucous from the mouth) them. At 2:09 PM, the resident was seated in their wheelchair in the hallway coughing and they had moved a towel to their mouth with their right hand. At 2:11 PM, Licensed Practical Nurse #33 asked the resident if they wanted to be suctioned again and the resident gave a thumbs up notion and was taken into their room by the nurse. - On 12/17/2024 at 11:44 AM sleeping in their wheelchair in the hallway. The December 2024 Treatment Administration Record documented placement of the Scopolamine patch was checked: - On 12/14/2024 on the 11:00 PM shift by Licensed Practical Nurse #32. - On 12/15/2024 on the 7:00 AM and 3:00 PM shifts by Licensed Practical Nurse #33 and on the 11:00 PM shift by Licensed Practical Nurse #34. - On 12/16/2024 on the 7:00 AM shift by Licensed Practical Nurse #33. There was no documented evidence the placement of the patch was checked on the 3:00 PM shift. On the 11:00 PM shift the placement of the patch was checked by Licensed Practical Nurse #34. - On 12/17/2024 on the 7:00 AM and 3:00 PM shifts by Licensed Practical Nurse #33. There was no documented evidence in the December 2024 nursing progress notes that a provider was notified the patch was not in place. During an observation and interview of oral suctioning care on 12/17/2024 at 12:45 PM, Licensed Practical Nurse #33 stated the resident was coughing quite a bit today and had more oral secretions than normal. The resident had large amounts of thick clear oral secretions. The resident was suctioned again by the nurse at 12:58 PM. At 2:54 PM, the resident was seated in their wheelchair in the hallway drooling. At 3:02 PM the resident was coughing in the hallway in their wheelchair when Licensed Practical Nurse #33 asked them if they wanted to be suctioned again and then took the resident to their room. During a telephone interview on 12/19/2024 at 10:01 AM, Licensed Practical Nurse #33 stated they placed a new scopolamine patch behind the resident's left ear on 12/17/2024 as ordered. The resident's patches came off easily and they expected the Certified Nurse Aides to let them know if the patch had fallen off, but they did not always tell them. They had seen the patch in the resident's bed before. There was no documentation in place for monitoring the placement of the patch and there was no routine check by nursing. The patch helped the resident to manage secretions and if it was not in place, they could have increased secretions and maybe that was why the resident had extra phlegm earlier in the week. They could not recall if the patch had been on prior to the new patch being applied on 12/17/2024 but thought it was behind the right ear. They were not sure what they were supposed to do if the patch had fallen off. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/2024 at 8:38 AM, Licensed Practical Nurse Assistant Unit Manager #22 stated the resident had a Scopolamine patch that was applied every 3 days. The nurses checked the patch was in place every shift. If it was signed off on the Treatment Administration Record, it meant the patch was in place. The Certified Nurse Aides could let the nurse know if they noticed it was off, but it was the nurse's responsibility to assure placement was checked. If the patch was not in place, the nurse needed to call the provider and the order would need to be adjusted. Resident #127's patch was known to fall off and if it was not in place, the resident could have increased secretions. Nurses were expected to follow physician orders. During an interview on 12/20/2024 at 8:56 AM, Nurse Practitioner #19 stated orders were expected to be followed for the safety of the residents. When they put an order in, they expected it to be executed as written. Resident #127's Scopolamine patch was ordered and helped manage their oral secretions. The patch was ordered to be placed every 3 days and placement of the patch was checked every shift. The resident perspired and sometimes the patch got wet with care and fell off. If the patch was not in place, a Registered Nurse needed to evaluate the resident and they expected to be notified to provide a new order. The patch was time released, so it required a new order. They had seen the resident on 12/18/2024 after being notified by Licensed Practical Nurse Assistant Unit Manager #22 of increased coughing and increased secretions and if the patch was not in place, it could have contributed to this. Increased secretions was a recurrent issue for the resident as their pharyngeal (throat) muscles were very weak and therefore, they could not manage their oral secretions. They had not been notified the patch was not in place, but they should have been. 10 NYCRR 415.12 49448

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48052 Based on record review and interviews during the recertification survey conducted 12/16/2024-12/20/2024, the facility did not ensure residents who required dialysis (a process that filters the blood for people in kidney failure) received such services consistent with professional standards of practice for 2 of 2 residents (Residents #14 and #29) reviewed. Specifically, the facility did not consistently assess Resident #14 and #29' medical condition and monitor for complications before and after dialysis treatments. Additionally, there was inconsistent communication and collaboration with the dialysis facility regarding care and services for Residents #14 and #29. Findings include: The facility policy, Dialysis Management, last reviewed 6/1/2024, documented the facility established open communication with the resident's dialysis center through a dialysis communication book and completed a dialysis communication form. A completed dialysis communication form contained pre-dialysis vital signs, advance directive status, and any pertinent resident information. Upon the resident's return from dialysis, the nurse reviewed the dialysis communication book pre-and-post-dialysis vital signs, treatment tolerance, any medications given, and any new orders documented for resident care. The nurse evaluated the resident post-dialysis for mental status, pain, access site condition, and response to treatment. The nurse notified the medical provider as needed after the dialysis communication book was reviewed and the evaluation of the resident was completed. The nurse documented findings in a nurses' note. 1) Resident #14 had diagnoses which included end stage renal disease and hypertension. The 11/13/2024 Minimum Data Set assessment documented the resident had intact cognition and received dialysis. The 10/11/2023 Comprehensive Care Plan documented the resident required dialysis related to end stage renal disease, five times a week, Monday through Friday. Interventions included check and change the dressing daily at the access site and document the condition and any complications; communicate with the dialysis center as needed; encourage the resident to attend their scheduled dialysis appointments; notify the nurse if bleeding was noted; obtain vital signs and weight per protocol and report significant changes immediately; and dialysis Monday through Friday at 9:00 AM with a pickup time of 8:45 AM. The 8/1/2024 physician order documented the resident had a permacath/central catheter (dialysis access site) to their right chest and to monitor for bleeding and placement every shift. If bleeding was noted, apply pressure, and notify the medical provider. If the permacath was dislodged, pressure was to be applied and 911 called. The 12/7/2024 physician order documented the resident was to attend in-house dialysis (a dialysis clinic located within the facility) five times a week, Monday through Friday with a drop off time of 6:30 AM for a chair time of 6:45 AM. There was no documented evidence pre-dialysis assessments were completed on: - 10/2/2024, 10/3/2024, 10/4/2024, 10/7/2024, 10/8/2024, 10/9/2024, 10/18/2024, and 10/31/2024. (continued on next page)

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 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bishop Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 11/1/2024, 11/4/2024 through 11/8/2024, and 11/14/2024. - 12/3/2024 and 12/9/2024. There was no documented evidence post-dialysis assessments and monitoring were completed: - on 10/1/2024 through 10/9/2024, 10/12/2024 through 10/16/2024, 10/18/2024 through 10/26/2024, and 10/28/2024 through 10/31/2024 - on 11/1/2024, 11/4/2024, 11/6/2024, 11/7/2024, 11/8/2024, 11/12/2024, 11/13/2024, 11/14/2024, 11/18/2024, 11/21/2024,11/22/2024 and 11/25/2024. - on 12/2/2024, 12/3/2024, 12/9/2024, 12/10/2024, 12/11/2024, 12/12/2024 and 12/13/2024. There was no documented evidence of dialysis communication logs for 11/7/2024, 11/14/2024, and 12/17/2024. 2) Resident #29 had diagnoses including end stage renal disease, type 2 diabetes mellitus with diabetic neuropathy (nerve damage), and dependence on renal dialysis. The 10/6/2024 Minimal Data Set assessment documented the resident had intact cognition and received dialysis. The 5/25/2022 comprehensive plan of care documented the resident needed hemodialysis related to end stage renal disease. Interventions included an arteriovenous fistula/ arteriovenous graft (dialysis access site, surgical connection between an artery and a vein) in their right arm; monitor for bruit and thrill (sound and vibration that the blood is flowing properly), notify the medical provider of its absence; monitor for bleeding, if noted, apply pressure and notify the medical provider; check and change the dressing daily at the access site, only change if ordered by the medical provider; document the condition and any complications; communicate with the dialysis center as needed; do not draw blood or take blood pressure in the right arm; monitor for any signs or symptoms of infection; encourage the resident to attend their dialysis appointments; and obtain vital signs and weight per protocol. The 12/8/2024 physician orders documented: - the arteriovenous fistula/arteriovenous graft was to be monitored for bruit and thrill every shift and notify the medical provider for absence; monitor for bleeding, if noted, apply pressure, and notify the medical provider; and no blood pressures in the right arm. - hemodialysis at an outside dialysis facility Monday, Wednesday, and Friday with a chair time of 5:30 AM and a medical cab pickup at 4:30 AM. There was no documented evidence the resident's pre-dialysis assessments were completed: - on 10/2/2024, 10/4/2024, 10/7/2024, 10/9/2024, and 10/18/2024. - on 11/1/2024, 11/4/2024, and 11/6/2024. - on 12/18/2024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence the resident's post-dialysis assessments were completed: - on 10/1/2024 to 10/9/2024 and 10/11/2024 to 10/31/2024. - on 11/4/2024, 11/6/2024, 11/15/2024, 11/18/2024, and 11/20/2024. - on 12/6/2024, 12/11/2024, 12/13/2024, and 12/18/2024. There was no documented evidence of a dialysis communication log on 12/2/2024. There was no documented response from dialysis and no documented follow up from the facility on the dialysis communication logs: - on 10/11/2024, 10/16/2024, 10/21/2024, and 10/25/2024. - on 11/4/2024, 11/6/2024, 11/8/2024, 11/13/2024, 11/15/2024, 11/18/2024, 11/22/2024, 11/2024/2024, and 11/29/2024. - on 12/2/2024, 12/11/2024, 12/13/2024, and 12/15/2024. During an interview on 12/19/2024 at 9:11 AM, Licensed Practical Nurse #24 stated they had to document an assessment on paper and in the computer prior to a resident leaving for dialysis. The paper assessment was placed in the communication book which went with the resident to dialysis. The post-dialysis assessment was done in the computer when the resident returned from dialysis. During a telephone interview on 12/19/2024 at 1:58 PM, Licensed Practical Nurse #25 stated during their shift their responsibility was to wait for the residents to come back to the floor from dialysis, check their access site, check the communication book from dialysis to see if any medications were given at dialysis, check their vitals, and then complete the post-dialysis assessment in the computer. Post-dialysis notes were to be completed after every dialysis session. The importance of a post-dialysis assessment was to see if there were any changes in the resident following the dialysis treatment. They were unaware they did not input a post-dialysis assessment for Resident #29 on several days in December 2024. They stated if a resident did not have a post-dialysis assessment in the computer there could be a miscommunication to the next shift nurse or if they had a reaction, the next nurse may not know. During an interview on 12/19/2024 at 2:02 PM, Licensed Practical Nurse Assistant Unit Manager #26 stated they sometimes helped with the post-dialysis assessments. The pre-dialysis and post-dialysis assessments were to be done every day the resident had dialysis. If the pre-dialysis assessment was not completed it would put the resident at risk for missing vital information. For example, if a resident received dialysis and had low blood pressure this could be dangerous to the resident. Resident #29 was diabetic, so it was important to know what their blood sugars were prior to dialysis and Resident #14 had chronic low blood pressure so it was important to have their blood pressures documented prior to dialysis. It was important to do a post-dialysis assessment in case the resident had a low blood pressure, or their dialysis port cite was bleeding. The dialysis communication sheets should be completed every dialysis day. The sheets communicated to the dialysis facility the resident's vital signs since the dialysis centers did not have access to the facility's electronic medical record. (continued on next page)

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/2024 at 2:15 PM, Registered Nurse Unit Manager #27 stated dialysis communication forms were to be filled out every time the resident had dialysis. The pre-dialysis assessment should be completed when the resident was getting ready to leave for dialysis and the post-dialysis assessment should be completed within 5-15 minutes of the resident's return from dialysis. It was important to do the pre- and post-dialysis assessments to make sure the resident's blood pressure was not too high or low. This information was also important to be communicated to the provider. It was important to check the resident's dialysis port/catheter site to monitor for bleeding. They were unaware Resident #29 had several days in December 2024 when they did not have post-dialysis assessments. They were also unaware Resident #14 had several days in December 2024 when they did not have pre-dialysis or post-dialysis assessments done. During a follow up interview on 12/20/2024 at 9:31 AM, they stated the nurses should check the dialysis communication forms and make sure they were filled out by both the facility and the dialysis center as this was the main form of communication between dialysis and the facility. If the communication sheets were not filled out by dialysis, the nurse should call the dialysis center and document in the electronic medical record. During an interview on 12/20/2024 at 8:27 AM, Registered Nurse #29 for the in-house dialysis den stated they received a communication logbook from the facility when a resident came for dialysis. They stated they were responsible for filling out their portion of the sheet to send back with the resident. They stated there were times they did not receive a filled-out communication form or no communication book at all from the facility. During an interview on 12/20/2024 at 9:04 AM, Licensed Practical Nurse #28 stated their responsibility for residents leaving for dialysis on their shift was to check the resident's site to ensure there was no bleeding or redness and the dressing was intact. They also checked the resident's blood pressure then put in the pre-dialysis note and fill out the communication form for the resident's dialysis book. The pre-dialysis assessment needed to be completed every dialysis treatment day. The importance of the pre-dialysis assessment was it provided communication with the next nurse to ensure they knew what was going on with the resident. They stated Resident #14 had low blood pressure and Resident #29 tended to have low blood sugars and not having those results documented or communicated could result in the resident getting a dialysis treatment and getting sick from the treatment. During an interview on 12/20/2024 at 11:06 AM, the Director of Nursing stated the facility was responsible for sending the dialysis communication sheets to the dialysis center. If the communication forms were not filled out by the dialysis center, they expected the nurses to call the dialysis center to obtain the needed information, especially the weights. It was important the sheets were filled out completely as that was the communication between the facility and the dialysis center. They expected pre- and post-dialysis assessments be completed every dialysis day. It was important the assessments were filled out each dialysis day as it was a process to evaluate the resident prior to going to dialysis and upon return from dialysis and to ensure anything that needed to be addressed immediately was communicated to the provider. During an interview on 12/20/2024 at 12:01 PM, Dialysis Administrator #30 for the outside dialysis facility stated their staff filled out the dialysis section of the communication book forms from the facility only if the pre-dialysis assessment on the form was completed so they could compare pre and post-dialysis information. If the resident did not bring their communication book with them to dialysis, they did not fill out anything for the nursing facility. They had not received any calls from the facility regarding Resident #29 ' s dialysis communication forms not being completed. (continued on next page)

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	335338	A. Building B. Wing	12/20/2024

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 NYCRR 415.12(K)

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NAME OF PROVIDER OR SUPPLIER Bishop Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 35045 Based on observations, record review, and interviews during the recertification survey conducted 12/16/2024-12/20/2024, the facility did not post daily current resident census and the total number, and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift in a prominent place readily accessible to residents and visitors for 5 of 5 days reviewed. Specifically, the current daily resident census and nurse staffing data was posted in an enclosed glass bulletin board across from the elevators of the 918 building, approximately 5 feet from the ground and not readily accessible to residents and visitors. Findings include: The facility policy, Staffing- Posting of Hours, Payroll Based Journal Submission, revised 10/2022, documented the facility would post hours in a clear readable format in a prominent place, readily accessible to residents and visitors. The daily resident census and nurse staffing information was observed posted in an enclosed glass bulletin board, approximately five feet from the ground across from the 918 building elevators: - on 12/16/2024 at 9:09 AM. - on 12/17/2024 at 8:32 AM. - on 12/18/2024 at 7:50 AM, and 11:19 AM. - on 12/19/2024 at 7:58 AM and 3:06 PM. - on 12/20/2024 at 8:34 AM. The posting was not accessible to all residents and visitors. During an interview on 12/19/2024 at 7:58 AM, Receptionist #2 stated the daily staffing was only posted in the nursing suite on the staffing coordinator door, and they were not familiar with the census /staffing document. During an interview and observation on 12/20/2024 at 8:57 AM, Staffing Coordinator #1 stated they were responsible to ensure the census and staffing was posted. The posted staffing and census for resident and visitors was in a glass bulletin board sealed on the wall of the 918 building across from the elevators. During an observation the shifts were not visible, but the census, the date, facility, and nursing staff licensed and non-licensed was visible. They stated the sign was about 5 feet from the floor and not all residents and visitors would be able to view the census. They also stated that if a visitor was going to the 906 building, they would not see the census and staffing due to the location of the posting. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/2024 at 9:33 AM, the Director of Nursing stated they were not aware the staffing was not posted in the lobby or in a location easily accessible to residents and visitors. They stated the posting of the census and nursing staffing should be in the lobby where the visitors came through. The census should be visible to all residents in the building, so they were aware of the nurse staffing hours and census. 10 NYCRR 415.13 48895

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43754 Based on observations, record review, and interviews during the recertification survey conducted 12/16/2024 - 12/20/2024, the facility did not ensure food was prepared, distributed, and served in accordance with professional standards for food service in the facility's main kitchen. Specifically, 2 of 4 walk-in coolers in the main kitchen were out of service for a prolonged period-of-time and the working walk-in coolers had unclean and uncleanable surfaces. Findings included: The facility policy, Food Service - Cleaning Standards Policy, last revised 1/2023, documented production, storage, and service equipment was cleaned and sanitized as required and recommended by the manufacturer. The facility policy, Food Service - Equipment Failure and Repair Policy, last revised 3/2022, documented: - food and nutrition equipment shall be maintained in a good state of repair. - staff were trained to report equipment that did not work or was not functioning properly. - supervisor or staff member report problem to Maintenance Department. - outside repair service shall be called if a problem cannot be corrected in a reasonable time frame by the facility maintenance staff. The following observations were made in the main kitchen: - on 12/16/2024 at 9:28 AM and 12/17/2024 at 1:10 PM, the front walk-in cooler had food spills and debris under the shelving. - on 12/16/2024 at 9:33 AM, the cook's walk-in cooler was out of service. - on 12/16/2024 at 9:37 AM, the Pull walk-in cooler was out of service. - on 12/16/2024 at 9:40 AM, the produce walk-in cooler had several broken floor tiles along the shared wall with the walk-in freezer. The broken tiles were not smooth easily cleanable surfaces. The facility work orders for the kitchen from 9/2024 to 12/2024 did not include documentation the Pull walk-in cooler and the cook's walk-in cooler were out of service or the produce walk-in cooler had broken floor tiles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/2024 at 1:41 PM, the Food Service Director stated the walk-in coolers were swept and mopped daily by assigned staff, but that was not documented. They stated the cook's walk-in cooler had been down a few weeks and the Pull walk-in cooler had been down since 9/2024. They stated they had not noticed the broken tiles in the produce cooler. If they had, they would have reported it to maintenance. Staff were all trained to report broken equipment and to notify supervisors. The supervisors would then make a verbal report to maintenance. They were not sure if maintenance documented anything on their end. They stated it was important the kitchen was kept clean, equipment was in working order, and surfaces were easily cleanable because this was the kitchen where the residents' meals were prepared, and they deserved to have a clean kitchen. 10NYCRR 415.14(h)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 43754 Based on observations, record review, and interviews during the recertification survey conducted 12/16/2024 - 12/20/2024, the facility was operating an unapproved dialysis den and was not in compliance with Federal, State, and Local Laws and Professional Standards. Specifically, the facility was providing hemodialysis (a process that filters blood for residents individuals with kidney failure) treatment in an unapproved space. Findings include: During an observation on 6/6/2024 at 9:29 AM, the dialysis den had 7 stations set up. The double doors that accessed the room, and the end of the corridor to the old therapy storage room had been walled off at the far end of the offices and bathrooms. Those areas were connected to the dialysis area, but on the approved plans were supposed to have been excluded. The wall was added at the wrong end of the corridor. During an interview on 6/10/2024 at 3:59 PM, the Administrator was informed the dialysis space had not been approved because construction to meet the approved plans had not been completed. They stated they did not know what construction needed to be done for the dialysis den and they were not aware of the approved plans. An email from the Department of Health to the Administrator dated 6/10/2024 at 8:03 PM, documented the approved plans were provided to the Administrator and they acknowledged receipt on 6/10/2024 at 8:26 PM. During observations on 12/18/2024 at 10:00 AM and 12/19/2024 at 9:20 AM, Resident #14 was at their in-house dialysis appointment at the facility dialysis den. On 12/20/2024 at 8:27 AM, Resident #14 was receiving dialysis treatment at the in-house dialysis den from Registered Nurse #29. During an observation on 12/18/2024 at 12:00 PM, the dialysis den remained unchanged from the observations in June 2024, more than 4 stations were set up, the double door entrance was not changed, and the corridor to the offices and bathrooms had the wall at the opposite end that than what was identified on the approved plans. During an interview on 12/18/2024 at 12:30 PM, the Administrator stated they were not aware of any changes or construction in the dialysis area. The vendor who performed the dialysis service was responsible for everything related to the dialysis operation, including the construction to meet the approved plans. They were not sure why the construction had not been completed or if their dialysis vendor wanted to amend the plans to match the existing facility. 2012 NFPA 101: 2.2 S483.70(a) Licensure. (continued on next page)

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	335338	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10NYCRR 400.2 incident reporting manual