

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER Bishop Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 918 James Street Syracuse, NY 13203	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335338
		If continuation sheet Page 1 of 38

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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) measuring 1.3 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 (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store food in accordance with professional standards for food service safety and did not follow proper sanitation practices to prevent the outbreak of food borne illness in one (1) of one (1) main kitchen and one (1) unit refrigerator (D South). Specifically, ten pans of prepared or leftover food in walk in coolers were not labelled; ten pans of fish were prepared and not labelled or dated; the dish machine wash temperature did not reach the required temperature; the dish machine sanitizer concentration was not monitored; Assistant Administrator #16 was in the main kitchen without a beard cover; there was debris and dried food built up on the floor and along the walls in the coolers and production areas; the reach in cooler gaskets had built up dried residue; and the unit refrigerator on D South had a dried sticky substance. Findings include: The facility policy Food Storage, revised 05/2024, documented all food would be clearly labeled and dated to assure that foods (including leftovers) would be consumed by their safe use by dates. All refrigerator units would be kept clean and in good working condition. Food Storage During an observation and interview on 04/27/2026 at 9:25 AM, the produce walk-in cooler in the main kitchen contained several unlabeled containers of prepared or leftover food dated 04/26, identified by the Food Service Director as fortified pudding, egg salad, plain tuna, tuna salad, pureed tuna, and apples. A partially covered pan of dessert was not labeled or dated and identified as cake. The Food Service Director stated the food should be labeled to prevent staff from serving the wrong item. During an observation on 04/27/2026 at 9:40 AM, walk-in cooler Number 2 had unlabeled containers of prepared or leftover food dated 04/26 identified by the Food Service Director as chicken, cucumber tomato salad, and pasta salad. During an observation on 04/27/2026 at 9:48 AM, the meat walk-in cooler contained ten pans of fish prepared the previous day. The Food Service Director stated the pans should be labeled and dated on the plastic cover. It should be labeled and dated so staff knew when it went into the cooler and what the item was. Sanitation The 02/25/2026 Emergency Service Report documented the dish machine final rinse did not reach the required 180 degrees Fahrenheit, and the dish machine was converted to a low temperature chemical sanitizing machine. The wash temperature was 128 degrees Fahrenheit, and the sanitizer concentration was 50 to 100 parts per million on several tests. The Food Service Director and Maintenance Director were notified of the change, and the Food Service director received an e-mail with the report. The 02/26/2026 through 04/08/2026 and 04/19/2026 through 04/26/2026 dish machine temperature logs, documented the wash temperature was exactly 150 degrees Fahrenheit and the final rinse was 180 degrees Fahrenheit (the requirement of a high temperature dish machine). There was no documented evidence the sanitizer strength was tested between the vendor testing on 02/25/2026 and 04/29/2026. The Low Dish Machine Temperature Log, initiated 04/29/2026 at 10:30 AM with the surveyor present, documented the dish machine wash temperature was 110 degrees Fahrenheit on 04/28/2026 midday. The vendor invoice dated 04/23/2026, documented the dish machine was serviced on 04/02/2026 and noted the temperature gauges did not work correctly. The repair was completed on 04/23/2026 and did not document any changes to the machine from high temperature to low temperature. During an observation and interview on 04/29/2026 at 10:15 AM, the dish machine wash temperature was 110 degrees Fahrenheit (minimum requirement is 120 degrees Fahrenheit) and was verified by the Food Service Director who stated they would call maintenance. They did not think it was an issue to use the machine if it did not reach the required wash temperature if the dishes were sanitized properly. They stated they thought the machine was out of service a week ago, around 04/12/2026, was converted from a high temperature machine to a low temperature chemical sanitizing machine and was tested on ce a day for a temperature check by whoever was running the dish machine that day. The April 2026 Dish Machine Temperature Log documented the following: -the dish machine temperature was to be tested three (3) times a day, once at each meal; - the required (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature for the wash cycle was 150 degrees Fahrenheit, and the final rinse was 180 degrees Fahrenheit;-entries were missing for the dinner meal on 04/08/2026, 04/09/2026, 04/10/2026, and 04/11/2026;-no temperatures were taken from 04/12/2026 through 04/18/2026;-the temperatures recorded on 04/19/2026 through 04/26/2026 were for a high temperature sanitizing machine, instead of a chemical sanitizing machine-there was no place to document the sanitizer chemical strength, and no evidence the sanitizer strength was tested in the dish machine since the conversion to chemical sanitizing.During an interview and observation on 04/29/2026 at 10:15 AM, the Food Service Director stated they did not have documented evidence they tested the chemical concentration of the dish machine. They stated they just got the new form today and that was why it was not in use yet. They did not know why the form in use was still documenting as a high temperature machine. They tested the sanitizer strength at 10:33 AM in the dish machine and it was in acceptable range to properly sanitize. They stated Food Service Worker #15 was responsible for documenting the dish machine temperatures on weekdays and a supervisor was supposed to test the sanitizer strength.During an interview on 04/29/2026 at 10:40 AM, Food Service Worker #15 stated they rotated positions in the kitchen and usually recorded the breakfast and lunch dish machine temperatures. The wash temperature should be 180 degrees Fahrenheit, and the sanitizing should be 170 degrees Fahrenheit. The facility just added chemicals to sanitize last week, and they did not know if that changed the required temperature readings. They stated they sanitized dishes to kill bacteria.During an observation and interview on 04/29/2026 from 11:00 AM through 11:30 AM, Assistant Administrator #16 was in the kitchen on the production floor and was not wearing a beard net to cover their full beard. The Food Service Director stated any staff, including vendors, were required to wear hair restraints and cover beards with a beard restraint anytime they entered any area of the kitchen.Equipment Safe/Clean:During an observation and interview on 04/27/2026 at 9:25 AM, the main kitchen had debris and dried food build up on the floor and along the walls in the production areas near the cook, the tray line, and dish washing areas. The reach in cooler gaskets had built up dried residue in them. The Food Service Director stated staff cleaned the kitchen daily but there were no formal cleaning schedules and staffing had been a struggle lately. Those areas should be cleaned daily to prevent bacteria growth.During an observation on 04/27/2026 at 11:30 AM, the refrigerator in the pantry on unit D South had a dried, and sticky substance built up on the bottom.During an interview on 05/01/2026 at 2:28 PM, the Food Service Director stated Administrative Assistant #16 knew they required a beard net because they had been told about that before. The unit refrigerators should be cleaned daily by dietary aides. 10 New York Codes, Rules and Regulations 415.14(h)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations and interviews, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition in one (1) of one (1) main kitchen. Specifically, the main kitchen walk-in freezer had ice built up on the floor and the compressor was leaking. Findings include: The facility policy Food Storage, revised 05/2024, documented all freezer units would be kept clean and in good working condition. Freezer temperatures should be checked at least two times each day and proper unit functioning would be checked at each temperature check. The facility policy Equipment Failure and Repair, revised 03/2022, documented staff was trained to report equipment that did not work or was not functioning properly to maintenance. Outside repair service would be called if problem could not be corrected in a reasonable time frame by facility maintenance staff. The 04/29/2026 vendor Duffy's AIS invoice stated the walk-in freezer was serviced on 04/28/2026 for extensive ice built up on the floor under the condenser. The unit was working properly, and the door gasket was in good repair. During an observation on 04/27/2026 at 09:25 AM, extensive ice was built up under the condenser and icicles were hanging off the compressor. The ice caused the shelving to be moved out a few feet from the wall. The reach in freezer and refrigerator number 1 (one) had ice built up in the back of the refrigerator near the condenser. Food Service Director #14 stated the freezer was just fixed recently and they were waiting until they were sure the problem was resolved before they cleaned up the ice. The refrigerator was likely opened recently and they would monitor it. During an observation and interview on 04/27/2026 at 1:44 PM, the floor beneath the compressor in the walk-in freezer was covered with icy build-up, several inches thick. Food product was moved from the area, but ice had spread almost a quarter of the total area of the freezer. Maintenance Director #17 stated the vendor Duffy's AIS was in the facility a week or two ago and thought the issue was resolved. During an observation and interview on 04/29/2026 at 11:30 AM, the freezer still had some ice and debris on the floor, and a small icicle was present on the drain line with some lines of ice on the back wall. The Administrator was present and stated they thought the problem had been fixed a week or two ago. There was ice observed around the wall and the Administrator had to close the door twice during the kitchen visit, after staff left the door slightly ajar. During an observation on 04/30/26 at 12:00 PM, the walk-in freezer had ice building up again and appeared to come from in front of the compressors and dripped from the ceiling. An icicle was noted on the drain line and ice on the back wall. During an observation on 05/01/2026 at 2:30 PM, most of the ice was gone from the floor, but icicles were noted hanging under the compressor. The gasket on the door appeared torn and part of it was hanging sideways. 10 New York Codes, Rules, and Regulations 415.5(e)(1)(2)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional standards and principles for two (2) of twelve medication carts (Unit C North and Unit 3 medications carts) and one (1) of two (2) treatment carts (Unit C South) reviewed. Specifically, the Unit C North medication cart was unlocked and unattended and contained pre-poured medications, expired eye drops and inhalers, and unlabeled insulin; the Unit 3 South medication cart had open unlabeled lidocaine (anesthetic) and expired insulin pens; and the Unit C South treatment cart was unlocked and unattended and contained scissors, antifungal cream, and antiseptics. Findings included: The facility policy Medication Storage and Labeling, last reviewed 01/21/2026, documented medications were stored safely and securely in a locked cabinet, cart or medication room that was accessible only to licensed nursing staff. Expired medications were removed from the medication storage areas and disposed of in accordance with state and federal regulations. The facility did not use outdated drugs or biologicals. Compartments containing drugs and biologicals were locked when not in use, when unattended, or when potentially available to others. The facility policy Administering Medications, last reviewed 12/2029, documented when multi-dose medications were opened the date opened was recorded on the container, and during administration of medications, the medication cart was kept closed and locked when out of sight of the medication nurse. Medications may not be prepared in advance and must be administered within 1 hour of their prescribed time. The medication cart was to be kept closed and locked when out of sight of the medication nurse. Unit C North Medication Cart and Unit C South Treatment Cart: During an observation and interview on 04/27/2026 at 9:24 AM, the Unit C North medication cart was unlocked and unattended. There were pre-poured medications on the cart which included Eliquis (blood thinner), Myrbetriq (for overactive bladder), Vitamin D, carvedilol (antihypertensive), magnesium (mineral), duloxetine (antidepressant), an eye vitamin tablet, pantoprazole (for reflux), and metformin (used to treat diabetes). A resident was standing next to the medication cart. There were no staff in the area. Licensed Practical Nurse #25 stated they should not leave medication on the cart or leave the cart unlocked and unattended; they must have gotten distracted. They stated leaving the medication cart unlocked was a safety issue. During an observation on 04/27/2026 at 2:34 PM, the Unit C North medication cart was unlocked and unattended. During an observation and interview on 04/28/2026 at 1:57 PM, the first drawer of the Unit C North medication cart contained one (1) bottle of expired eye drops; the second drawer contained an expired Ventolin inhaler, an expired Advair disk inhaler, and one (1) unlabeled insulin bottle. Licensed Practical Nurse #53 stated when they noticed a medication was not labeled or expired, they threw it out because it was no longer any good. During an observation on 04/29/2026 at 11:52 AM the C South treatment cart was unlocked and unattended. The cart contained a pair of scissors, antifungal cream, and antiseptics. During an interview on 04/30/2026 at 9:37 AM, Licensed Practical Nurse #24 stated medication and treatment carts should always be locked. There were items kept in both carts that could pose risk to residents. During an interview on 04/30/2026 at 12:34 PM, Licensed Practical Nurse Unit Manager #5 stated the medication and treatment carts should be locked when unattended. Medications should never be left on the carts unattended, and medications should be labeled once opened. Treatment carts contained wound cleanser, scissors, medicated creams, hair and mouth wash. All items posed risk to residents. They stated when a vial of insulin was opened it should be labeled to keep track of when it expired. There were many medications that required labeling when first opened by the nurse. Unit 3 South Medication Cart: During an observation and interview on 04/28/2026 at 1:48 PM the top drawer of the Unit 3 South medication cart had an open, unlabeled bottle of lidocaine (anesthetic). Licensed Practical Nurse #66 stated the lidocaine was most likely a one-time dose from the electronic medication dispensing (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	machine and they did not know when the bottle was opened. The second drawer contained two (2) expired insulin pens. Licensed Practical Nurse #66 stated both insulin pens were expired, and everyone was responsible for checking dates for expired medications. They stated they did not know why the pens or lidocaine bottle had not been removed. During an interview on 05/01/2026 at 10:24 AM, Assistant Director of Nursing #3 stated medication carts should be locked when unattended. They contained products that could cause harm to others. Insulins should be labeled after opening and carts should be organized. It was the responsibility of the licensed practical nurse that opened the medication to label the container. If insulin, eye drops, or inhalers were opened and the nurse did not see an open date on it, they should discard and reorder the items from pharmacy because they did not know what day it was opened. Treatment carts should always be locked. Many items in the carts could be dangerous to the residents. Medication and treatment carts should ever be left unattended while unlocked, and no medications should be left out on the carts. 10 New York Codes, Rules and Regulations 415.18(d)		

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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)		

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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. **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 d&eacute;cor, and cleanliness and order. The 1/16/2023 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. 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 (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observations, record review, and interviews, the facility failed to ensure allegations of abuse, neglect, or mistreatment were thoroughly investigated for two (2) of two (2) residents (Residents #267 and #290) reviewed. Specifically, Resident #267 alleged they were sexually abused and Resident #290 alleged they were physically and verbally abused and there was no documented evidence the facility completed a thorough investigation in response to the allegations or reported the allegations to the New York State Department of Health as required. Findings include: The facility policy Resident Rights, last reviewed on 05/28/2024 documented health care personnel shall treat all residents with kindness, respect and dignity. The facility policy Abuse, revised 07/18/2025, documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. Definitions of verbal abuse are oral, written or gestured language, that willfully includes disparaging and derogatory terms, to the resident/patient. Sexual abuse is non-consensual sexual contact of any type with a resident and includes, but is not limited to, humiliation, harassment, coercion or assault. 1) Resident #267 had diagnoses including depression, anxiety, and Alzheimer's disease. The 03/25/2026 Minimum Data Set assessment documented the resident had severely impaired cognition; anxiety and depression; hallucinated; had physical and verbal behavioral symptoms directed toward others; rejected care 4- 6 days but less than daily; was always incontinent of urine and bowel and received antianxiety medication daily. During an observation and interview on 04/27/2026 at 2:06 PM, Resident #267 was heard in their room yelling out they were sexually assaulted by [expletive] [cultural reference to country of origin]. Upon entering the room, the resident stated those [cultural reference to country of origin] raped them. The resident stated they wanted to speak to the head nurse. At 2:07 PM, upon exiting the resident's room Licensed Practical Nurse #63 informed the surveyor the resident yelled out all the time that the nurse aides were raping them. The resident called the staff racial slurs and threw random objects at them. The comprehensive care plan documented: -initiated 06/10/2022, and revised on 06/21/2023, the resident had actual resident to resident altercations as evidenced by throwing objects, yelling, and using foul language. Interventions included attempt to provide emotional support when the resident was angry, remove environmental triggers, and refer to psychiatry services. There were no documented behaviors of accusations of sexual assault or racial slurs. -initiated on 01/13/2023 and revised on 06/05/2025, the resident exhibited behavioral symptoms such as depressed mood, verbal and physical aggression toward staff when care was provided and refused to be positioned in bed for safety. Interventions included when behaviors occurred, verbally redirect the resident, acknowledge the resident's feelings, approach in a calm manner, and explain why the care was needed. There were no documented behaviors of accusations of sexual assault or racial slurs. The 03/10/2026 Nurse Practitioner #32 progress note documented the resident had a history of dementia with psychotic disturbance. The resident had disorganized thought process and mood was labile, ranging from pleasant to irritable within a short span of conversation. They had limited insight secondary to severe dementia. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 04/06/2026 at 1:37 PM, Social Worker #60 progress note documented a care plan meeting was held. The resident was not in attendance. There was no documentation the resident had a history of accusations of sexual assault. There was no documented evidence progress notes the resident reported being sexually assaulted. There was no evidence that the facility initiated an investigation for the alleged abuse or facility reported incidents related to sexual assault on file with the New York State Department of Health. During an interview on 04/28/2026 at 2:16 PM, Certified Nurse Aide #62 stated the resident made false accusation about the staff and said staff touched them and they were raped. They stated every time staff did the resident's urinary catheter care the resident used racial slurs. They told administration staff about the behaviors. The solution was to rotate the resident assigned care giver. During an interview on 04/29/2026 at 06:23 AM, Licensed Practical Nurse Unit Manager #61 stated Resident #267 called staff names and yelled out the staff were raping them when completing the resident's personal care. They stated they had not told the nursing supervisor about these comments. The resident was care planned for behaviors. The resident used to be on another floor, and they were not sure if the accusations of rape had been investigated. During an interview on 04/29/2026 at 11:18 AM, the Acting Director of Nursing stated they never heard the resident call out they were being raped. The resident did call the staff vulgar and racist names. They thought the resident was care planned for these behaviors. Anyone who heard the resident say they were raped, should complete a statement, and report to the supervisor and the medical provider. The resident would need a medical exam, and the police would have to be called. At this point, they were not aware of any incident reports for the resident regarding rape. This should have been reported immediately to the unit manager, and the unit manager should report to the supervisor who would complete an investigation and update the care plan after the investigation was completed. During an interview on 04/30/2026 at 11:53 AM, Nurse Practitioner #4 stated if there were accusations of rape, they would have been asked to complete an evaluation. The resident did mention to them they were raped by someone who worked at the facility but was not a nurse. They asked the resident if they felt they were being raped during personal care and the resident said yes. The resident said they felt like they were being violated when they were cleaned up after being incontinent. The resident stated they did not have any pain in their perineal area and did not answer any questions about their penis. They stated they thought the resident was associating their perineal care with being raped. 2) Resident #290 had diagnoses including depression. The 01/16/2026 Minimum Data Set assessment documented the resident had intact cognition; felt down or depressed in the last two to six days; had no behaviors; and was dependent on staff for most of their activities of daily living. The comprehensive care plan initiated on 11/18/2025 and updated on 03/29/2026, documented the resident exhibited behaviors such as mood changes, withdrawn, changes in appetites, and sleep disturbance related to depression. Interventions included checking the resident for toileting needs, providing care as indicated, determining the cause of the behaviors, distracting resident with preferred activities, and initiating psychiatric evaluation as needed. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/28/2026 at 9:24 AM, Resident #290 stated most of the staff do a good job, but there was one aide on the evening shift that was not good to them. They could not recall the aide's name, but they were mean, called them names, and hurt their leg. They stated they had their family member call the unit manager. They had not seen the nurse aide that was mean since that day, could not remember when it was, but the aide was removed from their care assignment. During a telephone interview on 04/28/2026 at 3:17 PM, the resident's emergency contact stated Resident #290 was coherent and able to make their needs known. They stated there was an incident where a nurse aide refused to turn and position the resident and said they would not help because the resident was too large. They stated this happened at the end of February 2026 or beginning of March 2026. They were not sure what the aide's name was because the aide refused to tell the resident their name. They called the Administrator multiple times, and they were transferred to voicemail or staff would tell them the Administrator did not want to talk to them. There was no documented evidence in the 02/13/2026 to 03/31/2026 nursing progress notes of the resident's reports of being verbally abused by nursing staff. There were no documented social work progress notes addressing the resident's allegations of abuse by a certified nurse aide. There were no documented facility reported incidents related to sexual assault with New York State Department of Health. There was no evidence that the facility initiated an investigation into the accusations of alleged abuse of Resident #290 During an interview on 04/30/2026 at 8:43 AM, Certified Nurse Aide #59 stated they took care of Resident #290 every other day; the resident was dependent on two staff for rolling and their personal care needs. They were not aware of any staff who was mean to the resident. If they heard someone call the resident names, or be disrespectful, they would report that to the unit manager. They did recall there was a complaint a couple of weeks ago. The resident told them an aide would not change them and called them names. But they did not know the aide's name. During an interview on 04/30/2026 at 9:40 AM, Licensed Practical Nurse Unit Manager #20 stated they reported incident and concerns to Assistant Director of Nursing #2. There was no dedicated registered nurse on their unit, and they were required to call the Registered Nurse Supervisor or the Assistant Director of Nursing. The resident had not voiced any concerns about care, but the resident's emergency contact voiced concerns about an aide that was not speaking to the resident respectfully. They stated there were no allegations of abuse or mistreatment, just the aide's tone of voice directed at the resident was not acceptable. The nurse aide still worked on the unit, but they did not assign them to Resident #290. They did not report this incident to their supervisor. During an interview on 04/30/2026 at 12:48 PM, the Acting Director of Nursing stated they were not aware there was a nurse aide that was mean to Resident #290. They called Licensed Practical Nurse Unit Manager #20 during the interview and inquired about the incident. They were told by Licensed Practical Nurse Unit Manager #20 there was an incident about a month ago with Certified Nurse Aide # 58 and Resident #290. They did not complete an incident report and just removed Certified Nurse Aide #58 from Resident #290's assignment. The Acting Director of Nursing stated the unit manager should have reported this immediately to the Registered Nurse Supervisor so they could follow up with the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident, the family and notify medical and complete an investigation to rule out abuse. 10 New York Codes Rules Regulations 415.4(b)(3)		

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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, 03/23/2026, 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews (IQIES intakes 2796359 and 2984903), the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (1) of one (1) resident (Resident #15) reviewed. Specifically, Resident #15 sustained a fall, was transferred to the hospital, returned to the facility with a fractured clavicle (collarbone), medical was not notified to address the fracture, a sling was not ordered as recommended, and there was no documented evidence the resident received an orthopedic follow up consultation as recommended. Findings include: The facility policy Change in Condition Notification, dated 08/2019, documented it was the facility policy to monitor residents for changes in their condition, to respond appropriately to those changes and to notify the physician and responsible party/family members of changes. The licensed nurse will record in the resident's medical record any significant changes in the resident's condition or medical status. The facility policy Change in Resident's Condition, last revised 05/2019, documented the facility should promptly notify the resident, their attending physician and the representative of changes in their medical condition. The nurse will notify the resident physician or on call physician when there has been an accident or incident involving the resident. The nurse will record in the resident's medical record information relative to changes in the resident medical or mental condition or status. Resident #15 had diagnoses including Alzheimer's, dementia, and muscle wasting. The 02/25/2026 Minimum Data Set documented the resident had severe cognitive impairment; did not reject care; used a walker; and required supervision for transfers and walking. The Comprehensive Care Plan initiated 02/10/2026 documented the resident required assistance with self-care and mobility related to confusion and dementia. Interventions included anticipating the resident's needs, call bell placed in reach, ensure the resident wears appropriate footwear for movement, and maintain a clutter free environment. The resident was at risk for falls related to confusion, incontinence, and poor communication. Interventions included pain evaluation, physical therapy to evaluate and treat as ordered, and provide a well-lit environment. The 02/10/2026 at 2:00 PM, Full Quality Assurance Report initiated by Licensed Practical Nurse Unit Manager #19 documented Resident #15 had a fall in the hallway/corridor while ambulating. The fall was witnessed by a staff member and was reported to Nurse Practitioner #4. The ambulance was called, and the resident was sent to the local hospital. The resident was newly admitted with diagnosis of dementia, was ambulating around the unit, and was found on the floor, lying on their right shoulder. The resident complained of pain to the right shoulder. The resident went to hospital to rule out a fracture to the right shoulder. The 02/10/2026 emergency room Triage progress note documented the resident had a witnessed fall at the nursing home. The resident hit their head and had just recently started Eliquis (a blood thinner) three days ago. This was their first day at that facility and they were wearing slippery socks. The computerized tomography scan (a quick detailed x-ray) of the spine was completed, and the resident sustained an acute right clavicle fracture. The resident was discharged home with follow up with an orthopedic provider and placed in sling. The 02/10/2026 at 9:35 PM, Registered Nurse #49 progress note documented the resident returned from the hospital at 9:00 PM with a new diagnosis of a closed fracture to the right clavicle. There was no documentation the medical provider was notified or an order for a sling was placed. There was no documented evidence the Physical Therapist #70 physical therapy discharge summary for service dates of 02/10/2026-02/19/2026 included a diagnosis or treatment plan for a fractured clavicle. There was no documented evidence of nursing notes addressing the resident's clavicle fracture or use of a sling from 02/11/2026-2/26/2026. The 02/27/2026 at 2:48 PM, Licensed Practical Nurse Unit Manager #19 progress note documented the local orthopedic practice sent a facsimile order for an x-ray of the right clavicle, and routine Tylenol every eight hours for pain. There was no documented evidence the resident attended an appointment with the orthopedic practice. The 02/27/2026 physician order documented right clavicle imaging to be (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed for abnormal mobility. The 02/27/2026 Radiology Results Report documented the resident had a right acute clavicle displaced fracture with osteopenia and arthritic changes. The 03/05/2026 at 1:53 PM, Physician #31 30-day progress note documented that the resident had an unwitnessed fall and sustained a right clavicular fracture, and the resident had bruising to their chest. The resident denied pain in the area. The 03/30/2026 orthopedic consult report documented the resident was seen and was referred to their practice by the emergency department for right clavicle after being seen in the emergency room on [DATE]. The resident had a fracture to right distal clavicle, initially evaluated at the hospital on [DATE]. Physical therapy was recommended for shoulder active and passive motion. Pain control measures were discussed, and the resident would be reassessed in four weeks to ensure progress. There was no documented evidence the orthopedic specialist was aware the resident had not worn a sling after discharge from the emergency department on 02/10/2026. During an interview on 04/30/2026 at 9:01 AM, Certified Nurse Aide #33 stated Resident #15 had a fall in 02/2026 and went to the hospital and returned the same day. They had to be reevaluated by therapy. They did not recall if the resident had a sling but there was a lot of bruising on their chest. During a telephone interview on 04/30/2026 at 9:26 AM, Registered Nurse Supervisor #49 stated when a resident returned from the hospital they did an assessment, checked their vital signs, checked the hospital paperwork and called the provider on call and put in any new orders, including follow up appointments. They entered a progress note in the record they had notified the on-call provider. They recalled the resident had a fracture. They stated they would have notified the provider upon the resident's return and there should be a progress note for the notification. They did not recall if the resident had a cast or a sling. There was a meeting the next day to follow up on the resident. There was a report sheet in the supervisor's office, to make note on any admissions, change in conditions, or anything irregular. If the resident had a fracture, they should have medical follow up and an orthopedic consultation. During an interview on 04/30/2026 at 11:00 AM, Licensed Practical Nurse Unit Manager #19 stated if a resident returned from the emergency in less than 24 hours they reviewed the after-visit summary with Nurse Practitioner #4, and they wrote down on the paperwork what Nurse Practitioner #4 wanted ordered. When a resident returned during off hours, the nursing supervisor was notified and would go to the resident unit. They were supposed to call the on-call provider, verify if there were new orders and notify the family. If the after-visit summary included a consultation, the consultation was entered in the record as an order. The physician liaison would follow up on this. If there was no after visit summary from the hospital, the supervisor should call the hospital. Resident #15 fell within the first day of admission and the nurse practitioner ordered to send the resident to the emergency room. The resident returned to the facility and there was an orthopedic consultant. They remembered putting the order in and communicating it. They were not sure if the resident was ever seen by the orthopedics team. The resident had a right closed fracture of the clavicle. Medical should be notified and there should have been a progress note that medical was notified. During an interview on 04/30/2026 at 11:22 AM, Physician Liaison #36 stated they set up all the appointments. They run a report to see who needs appointments, but if the nurses did not put an order in under consultants they would not know about it. Resident #15 went to the local orthopedic provider on 03/30/2026. During an interview on 04/30/2026 at 12:41 PM, the interim Director of Nursing stated when the resident returned from the emergency room, they get the paperwork and do an assessment and notify the family the resident was back. They provided the nurse practitioner with the new orders. If the hospital did not send anything, they called for records. If the resident had to go to a specialist, there would be an interdisciplinary team meeting form completed with the recommendation. They would review with the health care provider and notify the family of any changes. During a telephone interview on 04/30/2026 at 2:31 PM, Physician #31 stated if a resident was sent to the emergency room medical would see the resident when they returned from the hospital. They reviewed anyone who went to the emergency room every Wednesday. They reviewed the discharge summary or after visit summary. They stated there was a summary of an episode on (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the 02/10/2026 with Resident #15. They missed that one and was not told about the incident. They would have wanted to know about the fall, because the fall could interfere with the resident's daily activities and the resident was on blood thinners. If the emergency room identified the clavicle fracture, they would have placed a sling and called for an orthopedic consultation. The resident would need an order for the sling while at the nursing home and the resident would benefit from the use of a sling. They stated if staff did not notify them, they would only know if they went through their electronic chart. 10 New York Codes Rules Regulations 415.12		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, record review, and interviews the facility failed to ensure that residents who required dialysis services (a process that filters blood when the kidneys do not work efficiently) received such services consistent with professional standards of practice for one (1) of two (2) residents (Resident #70) reviewed. Specifically, Resident #70 did not have their fistula site (access for dialysis) checked and dressing removed as ordered and did not consistently have post dialysis assessments completed. Findings Include:Resident #70 had diagnoses including end stage kidney disease and dependence on dialysis. The 04/03/2026 Minimum Data Set assessment documented the resident had moderate cognitive impairment and required dialysis treatment.The comprehensive care plan initiated 10/01/2025 documented the resident received dialysis on Tuesdays, Thursdays, and Saturdays. Interventions included checking arteriovenous fistula in the left arm; monitor for bruit (sound caused by turbulent blood flow through fistula) and thrill (buzzing vibration felt with a fistula) every shift and document pre and post dialysis assessments.The 09/30/2025 physician order documented arteriovenous fistula, monitor for bruit and thrill every shift; notify the physician for absence; monitor the fistula for bleeding; if bleeding noted apply pressure and notify physician. The 01/20/2026 physician order documented remove the dressing to the left arm fistula after dialysis every day shift; every Wednesday, Friday, and Sunday. Resident #70's pre-dialysis progress notes dated 03/31/2026, 04/02/2026, 04/04/2026, 04/07/2026, 04/09/2027, 04/11/2026, 04/14/2026, 04/16/2026, 04/21/2026, 04/23/2026, 04/25/2026, and 04/28/2026, documented the resident attended dialysis. There were no documented post dialysis assessments/progress notes documented on 03/31/2026, 04/02/2026, and 04/21/2026 when the resident attended dialysis.The April 2026 treatment administration record did not include monitoring of the resident fistula 04/07/2026 on the evening shift, 04/20/2026 day shift, or 04/26/2026 evening shift.During an interview on 04/30/2026 at 10:51 AM, Licensed Practical Nurse Unit Manager #19 stated the resident attended dialysis and had a fistula located on the left arm. They stated it was important the access site was monitored before and after dialysis treatment, as it was an emergency if bleeding occurred. They stated vital signs were taken before and after dialysis and documented; and they believed the dressing was removed post dialysis.During an interview on 04/30/2026 at 12:31 PM, the Acting Director of Nursing stated assessments were supposed to occur before and after dialysis. Information about treatment was retrieved from the dialysis documentation and needed to complete the post dialysis assessment. The Director of Nursing stated if the there was no pre or post assessment documented, it was not a completed assessment 10 New York State Codes Rules and Regulations 415.11(a)(5)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observations, record review, and interviews, the facility failed to obtain consent and review the risks and benefits of bed rails (side rails) with a resident or the resident representative prior to installation of bed rails for one (1) of one (1) resident (Resident #209) reviewed. Specifically, Resident #209 had bed rails installed, and physician orders and informed consent were not obtained, and risks and benefits were not reviewed until after the installation of the bed rails; the use of bed rails was not included in the comprehensive care plan; and there were no ongoing assessments to ensure the bed rails continued to meet the resident's needs. Findings include: The facility policy Side Rails, revised 09/2019, documented each resident was assessed for functional status on admission, readmission, and quarterly for any significant change and as needed. The rehabilitation department might also be asked to evaluate the need for side rails as determined by the interdisciplinary team. The resident and/or their representative were provided with education regarding the decision on the use of side rails and side rail use was documented in the resident care plan. Staff obtained consent for the use of side rails from the resident or their representative prior to use. An order was obtained for use of the side rails by the physician. Maintenance staff installed the side rails and the maintenance director measured and reviewed proficiency in the practice of side rail safety utilizing the bed entrapment measuring tool. Resident #209 had diagnoses including multiple sclerosis (a progressive central nervous system disease) and reduced mobility. The 04/01/2026 Minimum Data Set assessment documented the resident had intact cognition; was dependent on transfers from the bed to the chair; required partial/moderate assistance to roll in bed; and did not use bed rails. The 10/22/2025 comprehensive care plan, revised 03/29/2026, documented the resident had limited physical mobility related to multiple sclerosis. Interventions included physical therapy, occupational therapy, and assistance with position changes and bed mobility. There was no documentation on the use of side rails. The undated care card instructions did not document use of bilateral side rails. The 12/09/2025 Director of Nursing #55 (previous Director of Nursing) Interdisciplinary Team Meeting progress note documented a restraint review for the use of side rails or enabler bars per resident request. Per the rehabilitation department the resident would benefit from bilateral enabler bars (side rails). The side rail was not a restraint. The side rail/enabler bar order was in place, the care plan was reviewed, and a consent was in place. The 12/09/2025 work order documented bilateral enabler bars were added Resident #209's bed. There was no documented evidence a physician order or consent was obtained, or risk and benefits of bed rails were reviewed prior to the installation of the bed rails. The 01/05/2025 physician order documented bilateral enabler bars (approximately 1 month after the installation of the side rails). The side rail consent form documented risks of the device and was signed by Resident #209 and Licensed Practical Nurse Unit Manager #5 on 01/05/2026. During an observation and interview on 04/27/2026 at 9:32 AM, bilateral enabler bars and an over the bed trapeze were observed on Resident #209's bed. The resident stated they used the bars and trapeze every day to move in bed. During an observation on 04/30/2026 at 8:35 AM, Resident #209 used both the right and left enabler bar to move from side to side, and the over bed trapeze to move in bed. During an interview on 04/30/2026 at 10:37 AM, the Director of Rehabilitation stated side rails were only used to improve residents' independence with bed mobility. The registered nurse completed the initial assessment then physical therapy evaluated the resident for appropriate use of side rails. The interdisciplinary team met and, if agreed upon, a request for enabler bars was put in the work order system for maintenance to apply the side rails. The side rails were typically installed by maintenance that same day and within 24 hours after installation, physical therapy evaluated the resident ensuring they used the side rails appropriately. Physical therapy evaluated appropriateness of the side rails quarterly. The Director of Rehabilitation looked in the computer and was unable to locate a consent (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form or review of risks and benefits for the resident's bed rails. There was a physical therapy discharge note on 12/19/2025 that did not document use of side rails. The 12/24/2025 physical therapy evaluation documented the resident enabler bars, and a trapeze prior to the evaluation. During an interview on 05/01/2026 at 9:37 AM, the Director of Maintenance stated they were responsible for installing side rails. They received the request for side rails from their electronic work order system and only accepted the request from physical therapy because the rails were an entrapment risk. They measured the bed and installed the rails within 24 hours. They were unable to recall when the side rails were installed for Resident #209 because they could only access the work order system back to February 2026. They stated only the Administrator had access to work orders prior to February 2026. During an interview on 05/01/2026 at 1:19 PM, Licensed Practical Nurse #27 stated side rails were used for increased mobility in bed but were not allowed because they were illegal in nursing homes. Since side rails were considered a restraint and not allowed, they were unsure why a consent would be obtained. Resident #209 had side rails, and they were unsure how the resident got them. During an interview on 05/01/2026 at 2:19 PM, Certified Nurse Aide #65 stated when a resident needed side rails to move in bed, physical therapy did an evaluation, the physician ordered them, and maintenance installed them. Resident #209 had side rails for months but was not sure when they were installed. During an interview on 05/01/2026 at 2:40 PM, Licensed Practical Nurse Unit Manager #5 stated side rails were used by residents who required assistance with bed mobility. Prior to installation of side rails, risks and benefits were reviewed with the resident and a consent was signed because there was a risk of entrapment. Prior to use of side rails, the registered nurse completed and documented an assessment in the computer and the nurse then sent a referral to physical therapy. The registered nurse assessment and consent was required prior to notifying maintenance. The request for side rails was put into the computer system as a work order for maintenance who applied the side rails. Side rails were documented in the resident care plan. They were unsure if a physician order was required or how often the physical therapy assessments were completed. Resident #209 had side rails, did not have the side rails documented on their care plan and should have. They were not sure when the consent for the side rails was obtained for Resident #209. 10 New York Code Rules Regulations 415.12(h)(1)(2)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observations, record review, and interview, the facility failed to ensure that licensed nurses had the appropriate competencies, and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for three (3) of three (3) licensed nurses (Licensed Practical Nurses #9 and #10, and Registered Nurse #13) reviewed. Specifically, Licensed Practical Nurses #9 and #10 performed wound assessments without registered nurse direct oversight; Registered Nurse #13 failed to identify and stage wounds on Resident #179's right and left legs; and Licensed Practical Nurses #9 and #10 and Registered Nurse #13 did not have competencies for wound care as part of the facility's designated wound care team. Substandard of Care was identified in treatment and services to prevent and heal pressure ulcers (F686). Findings included: The facility policy Wound Identification and Wound Rounds, revised 11/06/2023, documented the facility would identify, assess, and manage residents with pressure injuries, skin alterations, impairments, or wounds in accordance with current standards of practice. The registered nurse completed an initial wound assessment that included shape, size, depth and staging. A designated wound nurse or licensed nurse completed weekly wound rounds with a wound provider. Wounds were measured and assessed weekly and documented in the resident's electronic medical record in the Licensed Nurse: weekly wound evaluation and/or Wound care provider progress note. The facility policy Skin and Pressure Injury Prevention, revised 06/27/2024, documented residents were assessed on admission and re-admission for existing pressure and injury risk factors utilizing the Braden Risk Assessment (scale for predicting pressure). Braden Assessments were also conducted upon any change in resident condition. There was no documented facility policy for nursing assessments and assessment accuracy. The Facility Assessment Portfolio, revised 03/2026, documented specific care or practices included pressure injury prevention and care, skin care, wound care, and early identification of problems/deterioration. Upon hiring, all facility personnel participated in general orientation and job specific orientation. Each facility department had job specific orientation with pertinent training topics and policy/procedures for that discipline, with job specific curriculum and job specific competencies. Registered nurses and licensed practical nurses received one day of general orientation and two days of classroom training, preceptorship, and further training as determined by nursing leadership. Required competencies included person centered care and treatment competency. During an observation and interview on 05/05/2026 at 11:13 AM, Registered Nurse #13 assessed Resident #179's pressure wound. They stated they had last seen the wound two weeks prior and did not remember what it looked like. They removed the dressing from the left ankle and measured the wound as 1.2 centimeters by 1.4 centimeters and assessed the wound as a Stage 2 (partial-thickness skin loss with pink or red wound bed) pressure ulcer. Registered Nurse #13 stated they were unable to visualize the wound bed. They stated they did not notice the wound immediately above the right ankle wound. Licensed Practical Nurse #10 obscured the right ankle wound by placing their hand over the wound. They assessed the new wound as a Stage 2 pressure ulcer and measured it as 1.0 centimeter by 0.4 centimeter. The resident's leg was lying directly on a pillow, and an undated dressing was observed on the left lower lateral (outside) leg. Registered Nurse #13 stated they were unaware of the left outer ankle wound. They assessed it as a Stage 3 (full thickness tissue loss) pressure wound and measured it clustered by 4.3 centimeter by 1.0 centimeter. They stated they would inform the provider of the newly identified wounds. No further skin assessment was conducted. The facility document Clinical Competency Assessment, revised 12/2024, documented skills for dressing: aseptic/clean and wound vacuum assisted closure devices. There was no documentation provided for the qualifications of wound team nurses or specific wound team education. Nursing personnel records documented the most current completed competencies as followed: Licensed Practical Nurse #9 had demonstrated skills:- Dressing: aseptic/clean, completed (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 04/23/2025.- Wound vacuum assisted closure device, completed on 12/15/2025. There was no documented evidence of wound evaluation and Braden Risk Assessment education provided. Licensed Practical Nurse #10 had demonstrated skills:- Dressing: aseptic/clean, completed on 11/06/2024.- Wound vacuum assisted closure device, completed on 12/15. There was no documented evidence of wound evaluation and Braden Risk Assessment education provided. Registered Nurse #13 had demonstrated skills:- Dressing: aseptic/clean, completed on 12/17/2025.- Wound vacuum assisted closure device, completed on 12/15/2025. There was no documented evidence of wound assessment and Braden Risk Assessment education provided. 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. 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 stated they probably should not document 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 on the wound in the electronic medical record. They stated they could document data that was obtained 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 was healed and resolved it in the electronic medical record. 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. It was not possible to know if a registered nurse or provider attended wound rounds with them as there was no co-signature or documentation of such. 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 if a wound was healed or resolved. The registered nurse needed to assess the wound and write a note. 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 on the wound. During an interview on 05/05/2026 at 12:07 PM, the Administrator stated they had a wound team consisting 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. They were unsure if the wound team received education related to wounds. During an interview on 05/05/2026 at 12:25 PM, Nurse Consultant #69 stated licensed practical nurses were able to follow and evaluate wounds since an initial assessment was completed by a registered nurse and the registered nurse and provider accompanied them on wound rounds. The wound note was structured so the licensed practical nurse could document. Licensed practical nurses just collected data in collaboration with the wound care provider. There was a gap in time when there was no wound care provider. There was an area on the wound note to document that the provider was present during the evaluation. 10 New York Codes, Rules and Regulations 415.26(c)(1)(iv)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, record review, and interviews (iQIES Intake 2969603) the facility failed to ensure that residents were free of any significant medication errors for one (1) of two (2) resident (Resident #209) reviewed. Specifically, Resident #209 had a physician order for baclofen (a muscle relaxant and antispasmodic used to treat neurological conditions) four times a day and the medication was not administered within the prescribed time frame causing the resident discomfort. Findings include: The facility policy Medication Administration, last revised 12/2019, documented medications were administered in a safe and timely manner as prescribed. Medications were administered in accordance with the order including any time frame. Medications must not be prepared in advance and must be administered within (1) one hour of the prescribed time unless otherwise specified. If a medication was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication should document as such in a designated format. Resident #209 had diagnoses including multiple sclerosis (a progressive central nervous system disease) and muscle weakness. The 04/01/2026 Minimum Data Set assessment documented the resident had intact cognition and frequently had pain that affected their sleep and interfered with day to day activities with a reported pain rating of 7 (seven). The 10/23/2025 Comprehensive Care Plan, revised 03/29/2026, documented the resident had an alteration in comfort related to multiple sclerosis, limited mobility, trauma, pressure wounds, and muscle spasms. Interventions included administering medications as ordered, evaluating the effectiveness of pain interventions, reviewing for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, and using non-pharmacological interventions to promote comfort. The 04/20/2026 physician order documented baclofen 10 milligrams, give three tablets by mouth four times a day for muscle spasms. The April 2026 Medication Administration Record documented baclofen 10 milligrams give three tablets four times a day at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. Baclofen 10 milligrams three tablets were administered: -on 04/24/2026 at 11:01 AM by Licensed Practical Nurse #27 (2 hours late). -on 04/24/2026 at 2:27 PM by Licensed Practical Nurse #27 (1 hour and 27 minutes late). -on 04/24/2026 at 6:20 PM by Licensed Practical Nurse #52 (1 hour and 20 minutes late). -on 04/24/2026 at 8:07 PM by Licensed Practical Nurse #52 (within the prescribed timeframe, but 1 hour and 47 minutes after the previous dose was administered). -on 04/28/2026 at 2:32 PM by Licensed Practical Nurse #53 (32 minutes late). -on 04/30/2026 at 10:48 AM by Licensed Practical Nurse #12 (48 minutes late). There were no documented nursing progress reports regarding the late medication administration times of baclofen. The 03/18/2026 Physician #31 progress note documented they evaluated the resident for primary progressive multiple sclerosis, neuropathy, and reduced mobility. The resident's spasticity remained severe and uncomfortable and had only ever been treated with baclofen. The resident was to be seen at an upcoming appointment by a neurologist for further management. During an observation and interview on 04/30/2026 at 8:35 AM, Resident #209 stated they were prescribed baclofen four times a day and often received the first dose after 10:00 AM. When they were home, they took the medication first thing in the morning as it helped decrease pain and improve mobility. When they received the first dose of baclofen after 10:00 AM and received a second dose at 1:00 PM, the doses were too close together. They were on the medication for 30 years and when it was not properly administered at the prescribed times, they felt sick, nauseated, and had increased pain from muscle spasms. They stated at times they were unable to get out of bed because of the pain and muscle spasms. During an interview on 04/30/2026 at 1:17 PM, Licensed Practical Nurse #27 stated they were responsible for administering medications. Some medications were prescribed for administration at 8:00 AM and others for 9:00 AM allowing for staggering administration times so medications were administered according to the physician's order. All medications could be administered 1 hour before the assigned time or up to 1 hour after the assigned time. When a medication was ordered at 9:00 AM it could be administered any time between 8:00 AM and 10:00 AM. When a medication was (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered outside the ordered timeframe, they notified the supervisor. They believed the supervisor then notified the provider to ensure the medication could be administered outside the prescribed timeframe and documented it in a progress note. They stated it was important for residents to get the medications as ordered because they could interact if given too far apart or too close together. They administered Resident #209's 9:00 AM dose of baclofen on 04/30/2026 at 10:48 AM, the 9:00 AM dose on 04/24/2026 at 11:01 AM, and the 1:00 PM dose on 04/24/2026 at 2:27 PM. All the medications were administered late, and they did not notify the supervisor. Medications were administered late because breakfast trays were always late, they had insulins to administer, and trays to pass. During an interview on 05/01/2026 at 2:30 PM, Licensed Practical Nurse Unit Manager #5 stated they expected medications to be administered according to the physician's orders, the correct medication, correct dose, correct resident, and correct time. Medication administration had a window of time from 1 hour before the administration time until 1 hour after the administration time. Medications should be administered as ordered because they might interfere with other medications or could have side effects when given too close together. When a resident refused medications or they were administered outside the prescribed timeframe, they should be notified by the medication nurse, and a progress note should be written by the medication nurse. Resident #209 complained their baclofen was not always administered at the prescribed times. It was important for baclofen to be administered on time because without it Resident # 209 could not function throughout the day. Medications administered on 04/24/2026 at 11:01 AM, 04/24/2026 at 2:27 PM, 04/24/2026 at 6:20 PM, 04/24/2026 at 8:07 PM, 04/26/2026 at 10:18 AM, 04/26/2026 at 2:04 PM, 04/28/2026 at 2:32 PM, and 04/30/2026 at 10:48 were not timely. They were not notified the medications were not administered timely and should have been. During an interview on 05/01/2026 at 3:15 PM, Nurse Practitioner #4 stated they ordered baclofen for Resident #209 to help with pain from muscle spasms from multiple sclerosis. If the medication was not administered timely as ordered, side effects included somnolence (strong desire for sleep), increased pain, increased muscle spasms, and nausea. Resident #209 was just seen by their neurologist, and the provider recommended an increase of the medication to four tablets four times a day. The resident was on a high dose of baclofen because of the significant muscle spasms. It was important for the medication to be given early so the resident could function, eat, dress, and get out of bed. It was important for the medication to not be administered too close to the previous dose because the medication needed to work more consistently. 10 New York Codes, Rules, and Regulations 415.12(m)(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER Bishop Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 918 James Street Syracuse, NY 13203	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observations, record review, and interviews, the facility failed to provide routine and emergency dental services to meet the needs of each resident for one (1) of one (1) resident (Resident #296) reviewed. Specifically, Resident #296 was unable to have a dental procedure completed due to their anticoagulant (blood thinner) medication not being held prior to the procedure. Findings include: The facility policy Dental Services, last revised 09/2019, documented both routine and emergency dental services are available to meet the resident's oral health care needs based upon resident assessment and plan of care. Residents have the right to select a dentist of their choice when dental care or services are needed. Resident #296 had diagnoses including pulmonary embolism (blood clot in the lung), anxiety, and depression. The 04/12/2026 Minimum Data Set assessment documented the resident had intact cognition and received an anticoagulant (blood thinner). The comprehensive care plan initiated 07/01/2022, documented the resident was at risk for bleeding secondary to anticoagulant use. Interventions included administering medications as prescribed and monitor for sign and symptoms of abnormal bleeding such as skin bruising and bleeding gums. The 10/31/2025 physician order documented Xarelto (blood thinner) 10 milligrams daily at bedtime for history of pulmonary embolism. The 12/09/2025 Dental Consultation documented the resident presented with missing lower teeth. The 03/21/2026 Dental Consult, initiated by Nurse Practitioner #4 documented trauma to two bottom teeth which needed to be extracted. The 04/15/2026 physician order documented Xarelto 20 milligrams to be discontinued at bedtime. The April 2026 Medication Administration Record documented the following: -on 04/15/2026 at 7 PM- 9 PM, Xarelto was given as ordered. -on 04/16/2026 at 7 PM- 9 PM, Xarelto was not given and a 9 on 04/16/2026 indicating a nursing progress note was written. There was no documented nursing progress note on 04/16/2026. The 04/17/2026 at 4:21 PM, Licensed Practical Nurse Unit Manager #19 progress note documented the interdisciplinary team met regarding Resident #296's 04/17/2026 dental consultation. The updated orders, including the blood thinners, would need to be held for two days prior to procedure which was rescheduled for early next month. During an interview and observation on 04/27/2026 at 10:04 AM, Resident #296 stated they were upset they were supposed to have two teeth extracted, they had the appointment since last month. They were supposed to have medications held and this did not happen. They stated communications within the facility often fell through the cracks. They stated they did not want to be seen with two front teeth missing/cracked. The dentist visited them and said the two broken teeth needed to be removed. When the dental assistant came to get them for the procedure, they informed the dental assistant the facility did not hold their medications. The dentist said they were unable to do the procedure because their medication was not held for three days. During an interview on 04/30/2026 at 10:31 AM, Licensed Practical Unit Manager #19 stated they have an outside contracted dentist. Physician Liaison #36 usually took care of any referrals and appointments. When they got the consultation paperwork from the Physician Liaison, they looked them over and reached out to the Nurse Practitioner #4 to go over them. The nurse practitioner would initial the referral once they put the orders in. Licensed Practical Unit Manager #19 stated they would document a progress note in the Interdisciplinary meetings section which included who the residents saw, who was aware and what type of consultation. If they were to hold blood thinners, this was usually a hold order for three days prior to procedure. They stated the team was aware of the dental procedure coming up. When the dentist said they could not do the procedure, the resident was disappointed. They stated they may have made a mistake with the orders and may have been rushing. They did not have a chance to add the order with dates to hold medication and just put in the order for the day of the dentist's visit. During an interview on 04/30/2026 at 11:44 AM, Nurse Practitioner #4 stated dental was just like any other consultation and any orders must go through the health care provider. They spoke to the dentist, and they said they were going to extract Resident #296's teeth. They gave a verbal order to Licensed Practical Nurse Unit Manager #19 and thought that the (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's blood thinner was on hold. They realized the night before the procedure the medication was not held for the time frame the dentist wanted. There was a miscommunication. 10NYCRR 415.17 (a-d)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (2) of six (6) residents (Residents #8 and Resident #270) reviewed. Specifically, Resident #8 was on enhanced barrier precautions and Licensed Practical Nurse #6 administered the resident's tube feeding and completed a dressing change without appropriate personal protective equipment; and Resident #270 was on enhanced barrier precautions and Licensed Practical Nurse #25 completed the resident's wound dressing without appropriate personal protective equipment. Findings include: The facility policy Personal Protective Equipment, revised 02/25/2026, documented an isolation gown is worn during high contact resident care activities when contact precautions do not apply. Gloves are worn when anticipated contact with blood or body fluids, mucous membrane contact or contact with non-intact skin. The facility Enhanced Barrier Precautions signage documented everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and gowns for high contact resident care activities, including device care or use of feeding tube, and any skin opening requiring a dressing.1) Resident #8 had diagnoses including a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer of sacral region and bacteremia (bacteria in the blood stream). The 04/01/2026 Minimum Data Set assessment documented the resident had wounds. The 04/11/2026 Comprehensive Care Plan, revised 04/20/2026, documented the resident had colonized multidrug resistant organisms including Vancomycin Resistant Enterococci (type of bacteria). Interventions included monitor resident for worsening signs of infection, enhanced barrier precautions: wear gown and gloves when providing high contact activities at the bedside including dressing, device care and/or use or wound care; remove personal protective equipment and perform hand hygiene and reapply as necessary before providing care for another resident. Physician orders documented: -04/20/2026 enteral feeding tube dressing change every 24 hours as needed for soiling, cleanse area with soap and water or normal saline, and apply a dry dressing. -04/21/2026 enteral tube feeding, Jevity 1.5 at 51 milliliter per hour to begin at 6:00 PM, for total volume of 1800 milliliter every shift for dysphagia (difficulty swallowing). During an observation and interview on 04/30/2026 at 5:39 PM, the resident's room had an enhanced barrier precaution sign posted with a personal protective bin outside the room. Licensed Practical Nurse #6 labeled the resident's tube feeding with date and time, put on gloves, and entered the resident's room without a gown. Licensed Practical Nurse #6 opened the flush bag, went into the bathroom and put water in the flush bag, and clamped the tube. They discarded the old tube feeding container, tubing and flush bag. They changed their gloves and did not perform hand hygiene. They removed the old dressing around the residents' feeding tube site, cleansed with normal saline and applied a new dressing. They primed the tube feeding and turned on the tube feeding pump. They stated gowns were only worn when they were doing dressing changes and they did not have to wear a gown when setting up a tube feeding.2) Resident #270 had diagnoses of chronic kidney disease and cancer. The 04/03/2026 Minimum Data Set assessment documented the resident had intact cognition, had moisture associated skin damage, and application of ointment/medications. The 03/26/2026 Comprehensive Care Plan, documented the resident was at risk for impaired skin integrity related to impaired mobility, renal disease and incontinence. Interventions included applying protective skin care, minimizing extended exposure to skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing. The care plan did not include enhanced barrier precautions. The 04/17/2026 physician order documented the left shin should be cleansed with normal saline, apply a Xero foam gauze to wound bed, and cover with border gauze every shift for wound care. During observations on 04/27/2026 at 2:34 PM and 04/29/2026 at 12:00 PM, Licensed Practical Nurse #25 performed the resident's dressing change. They did not wear a gown. The enhanced barrier (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	precautions sign outside the door to the resident's room, instructed staff to wear a gown and gloves when doing a dressing change. During an interview on 04/29/2026 at 12:12 PM, Licensed Practical Nurse #25 stated they did receive general training on infection control, but they did not know what the signs outside the resident's door meant. They did not wear a gown when doing Resident #270's dressing either day because they did not know what the signs meant. They stated they worked alone during the weekend shifts, and the personal protective equipment was not always stocked so they did not always wear a gown. Gowns were worn when doing dressing changes to prevent the spread of infection. During an interview on 04/30/2026 at 12:47 PM, Licensed Practical Nurse Unit Manager #5 stated everyone was trained in infection control and the staff received monthly training. The residents on precautions had a sign outside their room door and the sign for enhanced barrier precautions instructed staff to clean their hands, wear gloves, and gowns. The nursing staff should follow the directions to prevent the spread of infection. During an interview on 05/01/2026 at 11:30 AM the Assistant Director of Nursing (interim Infection Preventionist) stated when completing a dressing change for tube feeding site and preparing a tube feeding, staff should wear gowns and gloves. Staff should put on the personal protective equipment prior to entering the residents' room and remove the personal protective equipment prior to leaving the residents' room. Gowns and gloves were important to protect the residents and staff from cross contamination of germs. There were signs outside of each precaution room notifying staff of what personal protective equipment was required. Staff were educated on personal protective equipment during orientation, yearly and as needed.10 New York Codes, Rules and Regulations 415.19(a)(b)		