STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335489	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningstar Residential Care Center	17 Sunrise Terrace Oswego, NY 13126

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335489	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningstar Residential Care Center	17 Sunrise Terrace Oswego, NY 13126

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview during the abbreviated survey (NY00323539/IQIES 652830), the facility did not ensure residents with pressure ulcers or at risk of 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 1 of 3 residents (Resident #3). Specifically: Resident #3 developed a new pressure ulcer that was not assessed and was not treated timely. Two weeks after the wound developed, the facility investigated the pressure ulcer and concluded the wound was not assessed, there was no treatment order implemented, and was not documented.Findings include:The facility policy, Pressure Ulcer Prevention Program, revised 1/31/2017, documented the facility should have a system in place that assured assessments were timely and appropriate, interventions were implemented, monitored and revised as appropriate; and changes in condition were recognized, evaluated, reported to the resident's attending practitioner and other health care professionals, i.e., wound nurse, as appropriate. Resident #3 had diagnoses including heart failure and weakness. The 7/12/2023 Minimum Data Set assessment documented the resident's cognition was intact and they required partial/moderate assistance with rolling left and right and partial/moderate assistance with chair/bed-to-chair transfers. The resident had no unhealed pressure ulcers.The 7/14/2023 Comprehensive Care Plan documented the resident was at risk of skin breakdown related to deconditioning. Interventions included risk assessments, keep skin clean and dry and massage with emollients during cares.Between 7/14/2023 and 8/31/2023, there was no documented evidence in the electronic record that the resident had any skin related concerns.The 9/1/2023 Wound Flow Sheet completed by former Director of Nursing #5 documented the resident had a new unstageable pressure ulcer (full thickness skin and tissue loss) on the left heel that was 2.5 centimeters (width) by 2.7 centimeters (length) by 0.4 centimeters (depth). The wound had moderate seropurulent (thin, watery, yellow to tan) drainage and the wound bed had necrotic tissue (non-viable tissue). A treatment order was obtained, and new interventions included a low air loss mattress, a pressure reducing cushion and mattress, and foam booties.The 9/1/2023 physician order documented Santyl (wound treatment) to the left the heel and cover with a dry dressing daily. The undated/unsigned facility investigation (later determined in interview it was completed by former Director of Nursing #5) documented on 9/1/2023, they became aware Resident #3 had an unstageable pressure injury on their left lateral (to the side, away from midline) heel that was 2.5 centimeters by 2.7 centimeters by 0.4 centimeters. After interviews and investigation, it was concluded the resident's pressure injury was noted by a certified nurse aide (later determined to be Certified Nurse Aide #1) on 8/18/2023. The certified nurse aide notified the licensed practical nurse (later determined to be Licensed Practical Nurse #3) and the licensed practical nurse reported it to the registered nurse supervisor (later identified to be Registered Nurse Supervisor #4). There was no documentation found regarding the resident's wound by the licensed practical nurse or the registered nurse supervisor, a treatment was not implemented and there was no documentation of notification to the Residential Care Coordinator, the Director of Nursing or the physician. Staff statements documented:- on 9/1/2023, from Certified Nurse Aide #1, on 8/18/2023, they found an open wound on the resident's left heel and reported it to Licensed Practical Nurse #3 who had Registered Nurse #4 evaluate the resident's heel.- from Licensed Practical Nurse #3 (undated), about 3 weeks ago, Certified Nurse Aide #1 reported a wound to them on the resident's heel that appeared to be a pressure ulcer. Licensed Practical Nurse #3 notified Registered Nurse #4 who assessed the resident and never mentioned a treatment plan. When they saw Registered Nurse Supervisor #4 later that shift, they asked about the plan for the resident's foot and Registered Nurse Supervisor #4 stated they did not know. When they asked if Registered Nurse Supervisor #4 wanted the resident's wound placed on the report, Registered Nurse Supervisor #4 stated it did not need to go on report, and they would discuss it with Resident Care Coordinator #5 the next day. Licensed Practical Nurse #3 stated they did not document the resident's wound and should have.- on 9/5/2023, from Registered Nurse Supervisor #4, they did not recall the events of the resident's heel on 8/18/2023. They typically documented a note after they assessed a resident and because the event was not documented, they were not told to assess the resident.- on 9/7/2023, Certified Nurse Aide #2 documented they were aware Certified Nurse Aide #1 found a wound on the resident's heel and reported it to Licensed Practical Nurse #3 who reported to Registered Nurse Supervisor #4 who looked at the resident's wound. Certified Nurse Aide #2 overheard Licensed Practical Nurse #3 ask Registered Nurse Supervisor #4 if they wanted the resident's wound placed on report however they did not hear their answer as they had walked