STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335541	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Care Community of New York	2150 Bleecker Street Utica, NY 13501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life for three (3) of three (3) residents (Residents #30, #190, and #288) reviewed. Specifically, staff stood over Residents #30, #190, and #288 while assisting them with feeding.Findings include:The facility policy Resident Dignity, revised 09/2025, documented the facility ensured all residents were treated with dignity and provided residents with a dignified dining experience. 1) Resident #30 had diagnoses including Alzheimer disease and dysphagia (difficulty swallowing). The 12/31/2025 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, required substantial/ maximum assistance with eating, and received a mechanically altered diet. The Comprehensive Care Plan, initiated 08/13/2024 and revised 03/31/2026, documented the resident required substantial/ maximum assistance with eating.The 01/15/2025 physician order documented the resident was on a regular puree diet with thin liquids.During an observation on 04/01/2026 at 8:09 AM Resident #30 was seated at a table for the breakfast meal. Certified Nurse Aide #23 was standing while assisting Resident #30 with their meal. 2) Resident #190 had diagnoses of Alzheimer's disease and dysphagia (difficulty swallowing). The 02/26/2026 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, was dependent with eating, and received a mechanically altered diet.The 01/23/2026 physician order documented the resident was on a puree diet with nectar consistency liquids.The Comprehensive Care Plan, initiated 09/24/2025 and revised 02/25/2026, documented the resident was dependent with eating.During an observation on 04/01/2026 at 8:09 AM Resident #109 was seated at a table for the breakfast meal. Certified Nurse Aide #23 was standing while assisting Resident #109 with their meal. 3) Resident #288 had diagnoses of Alzheimer's disease and dysphagia (difficulty swallowing). The 02/16/2026 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, was dependent with eating, and received a mechanically altered diet.The 03/30/2026 physician order documented a regular puree thin liquid diet.The Comprehensive Care Plan, initiated 06/25/2025 and revised 03/25/2026, documented the resident was dependent with eating.During a meal observation on 03/30/2026 at 12:22 PM, Resident #288 was seated at a table for the lunch meal. Certified Nurse Aide #25 was standing while assisting Resident #288 with their meal. During a meal observation on 04/01/2026 at 8:09 AM, Resident #288 was seated at a table for the breakfast meal. Certified Nurse Aide #23 was standing while assisting Resident #288 with their meal. During an interview on 04/01/2026 at 02:22 PM, Certified Nurse Aide #23 stated they assisted residents at meals and was trained to offer bites of food and alternate with sips of liquids. They were supposed to be seated at eye level when assisting residents at meals for dignity reasons. The facility had enough chairs to be seated during meals, but the unit had several residents who needed assistance at meals, so they stood while assisting all the residents during the meal. They stated it was not dignified to stand while assisting the residents with their meals. During an interview on 04/01/2026 at 2:31 PM Licensed Practical Nurse #24 stated staff should be seated while assisting residents with meals.During an interview on 04/06/2026 at 10:04 AM Registered Nurse Neighborhood (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager #12 stated staff should be seated when assisting the residents at meals. Standing while assisting residents with their meals was not dignified.10 New York Codes, Rules and Regulations 415.23(c)(1)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record review, and interviews (iQIES Intake 2722137) the facility failed to ensure routine and emergency drugs and biologicals were provided to two (2) of two (2) residents (Residents #14 and #247) reviewed. Specifically, three (3) doses of Resident #14's alprazolam (used to treat anxiety) were not administered due to the medication not being available from pharmacy; and Resident #247 was not administered five different medications (diltiazem, methimazole, nadolol, hydralazine, and lisinopril) between February 2026 and March 2026 due to the medications not being available from pharmacy. Findings include:The facility policy Medication Administration, revised 10/2025, documented if a medication was not available at the time it was to be administered, the nurse was to notify the neighborhood manager or supervisor. The neighborhood manager or supervisor would explore alternate methods for obtaining the medication such as the emergency medication supply, contacting the pharmacy, or contacting medical for alternate medication. The facility policy Medication Ordering, last reviewed 12/2025, documented all medication nurses were responsible for ordering medications. All new medications and medication refills were ordered electronically through the electronic medical record. The nurse would need to speak to a pharmacist to communicate the status of orders and urgency for medications needed prior to the morning delivery. Orders sent to pharmacy by 9:00 AM were to be delivered on the first pharmacy run; orders sent by 1:00 PM, were delivered on the second run; and orders by 7:00 PM were on the last delivery. The nurse was responsible for monitoring refill requests through General Dashboard Notification Box. If a transmission error appeared, the nurse was to contact the pharmacy regarding need to reorder. If a refill was rejected, the nurse was to review reason. If reason was too soon to fill, the nurse was to review the medication supply. If the medication was needed, the nurse was to contact the pharmacy. All other reasons the nurse should also contact the pharmacy. 1) Resident #247 had diagnoses including atrial fibrillation (irregular heartbeat), hypothyroidism, and congestive heart failure. The 02/13/2026 Minimum Data Set documented the resident was cognitively intact, had no behaviors, and took an antidepressant. The 08/06/2025 comprehensive care plan revised 01/19/2026 documented: - the resident had the potential for complications related to hypothyroidism. Interventions included administering medications as ordered and monitor response. - the resident had cardiovascular disease and had the potential for complications secondary to hypertension, congestive heart failure, and atrial fibrillation. Interventions included to provide medication and treatment per physician's orders and monitor for side effects of medication and inform the physician of concerns. Physician order documented: -on 08/04/2025 one (1) capsule of 120 milligrams of diltiazem extended release (a heart medication) by mouth once daily for atrial fibrillation. -on 8/04/2025 one (1) 5 milligram tablet of methimazole (a thyroid medication) by mouth six (6) times a week Monday-Saturday for thyrotoxicosis (excessive thyroid hormone in the blood stream). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-on 08/04/2025 one (1) 80 milligram tablet of nadolol by mouth once daily for hypertension (high blood pressure). -on 12/31/2025 one (1) 50 milligrams tablet of hydralazine for hypertension. -02/06/2026 one (1) 2.5 milligrams tablet of lisinopril (a heart medication) by mouth one time a day for atrial fibrillation. The February 2026 Medication Administration Record documented the resident was not administered the following medications: -on 02/17/2026 at 2:00 PM, one (1) 50 milligram tablet of hydralazine; marked as not administered due to being re-ordered by Registered Nurse Neighborhood Manager #29. -on 02/25/2026 at 8:00 AM, one (1) 120 milligram capsule of diltiazem extended release; marked not administered with the supervisor aware by Licensed practical Nurse #53. -on 02/26/2026 at 8:00 AM, one (1) 120 milligram capsule of diltiazem extended release; marked not administered with the supervisor aware by Licensed Practical Nurse #28. The March 2026 Medication Administration Record documented the resident was not administered the following medications: -on 03/10/2026 at 8:00 AM, one (1) tablet of lisinopril 2.5 milligrams; marked as waiting on pharmacy by Licensed Practical Nurse #57. -on 03/28/2026 at 8:00 AM, one (1) tablet of methimazole 5 milligrams and one (1) capsule of 120 milligrams of diltiazem extended release; marked as not available by Licensed Practical Nurse #58. -on 03/29/2026 at 8:00 AM, one (1) tablet of nadolol 80 milligrams; marked as awaiting delivery by Licensed Practical Nurse #59. The 01/26/2026 Inventory Summary for the facility's emergency medication supply documented hydralazine 25 milligram tablets were kept stocked. The resident's blood pressure was documented on 03/28/2026 at 9:23 AM as 180/82 (high) after their missed dose of diltiazem. There was no documented evidence the provider was notified regarding the resident's missed medications and elevated blood pressure. The 03/29/2026 Registered Nurse Neighborhood Manager #29 progress note documented the resident did not receive nadolol that morning. The resident's adult child was concerned about the missed dose. The resident's blood pressure was 131/84. The resident was going out with their family and the resident's adult child requested the resident's blood pressure be rechecked upon the resident's return. The scheduled dose would be administered the next morning after it was delivered. An email was sent to the medical team. There was no documented evidence a supervisor was made aware of the missed doses of medications on 02/17/2026, 03/10/2026, and 03/28/2026. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was no documented evidence the medical providers were made aware of the missed doses of medications on 02/17/2026, 02/25/2026, 02/26/2026, 03/10/2026, and 03/28/2026. During an interview on 04/02/2026 at 10:05 AM, Licensed Practical Nurse #28 stated if a resident ran out of medications, they should check the emergency medication supply to see if it was stocked. If it was not, they should notify the supervisor and call the pharmacy to see when it would be delivered. The supervisor was responsible for notifying the provider. On 02/26/2026 Resident #247 missed their 8:00 AM diltiazem dose because the medication was out. They informed Registered Nurse Neighborhood Manager #29. They sometimes ran out of medications due to the medication not being reordered and because the pharmacy did not deliver timely. During an interview on 04/02/2026 at 11:55 AM, Licensed Practical Nurse #53 stated non-narcotic medications were reordered by clicking a button in the electronic medical record. The new pharmacy was not great with refilling medications, and the nurses usually had to call and make sure the refill went through. Medications should be ordered within five (5) days of the last dose. Not all the nurses checked the supply left when administering medications. If a resident did not have a medication, the nurse should check the emergency medication dispensing machine to see if there were tablets to equate the dose. If there were not, they should contact the supervisor to discuss next steps as well as call the pharmacy. The supervisor was responsible for notifying the physician. The 02/25/2026 dose of diltiazem for Resident #247 was not available as the medication was out. They called the supervisor, checked the emergency medication supply dispensing machine which did not have it. When they called the pharmacy, they were told the resident's insurance was the issue because it was too early to fill it. There was no alternative given and the resident was not placed on additional monitoring. During an interview on 04/03/2026, Registered Nurse Neighborhood Manager #29 stated medications should be reordered when the resident was down to a three (3) day supply, not the last day. They stated medications were ordered late. If the resident was out of medication, the nurses should check the emergency medication supply dispensing machine. The supervisor or neighborhood manager should be informed. The supervisor or neighborhood manager should call medical if the medication was not available in the emergency supply and see if it was alright for the resident not to receive the medication or if a different medication should be given. A note should be entered into the electronic medical record regarding the missed dose and the provider notification. The nurses ran into issues with ordering medications and medications being delivered timely by the pharmacy. They were only aware of the 03/29/2026 missed dose of the nadolol for Resident #247, not the other missed medications in February 2026 and March 2026. 2) Resident #14 had diagnoses including Alzheimer's disease and anxiety. The 03/11/2026 Minimum Data Set assessment documented the resident had severely impaired cognition and received antianxiety medication. The 10/22/2025 Comprehensive Care Plan, revised 03/23/2026, documented the resident had alteration in mood related to anxiety, depression, and Alzheimer's dementia. Interventions included to give clear, concise explanations regarding impending procedures, assist with decision making as needed, and provide reassurance and comfort. The 01/12/2026 physician order documented alprazolam 0.25 milligram tablet orally four times per day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The January 2026 Resident Medication Administration Record documented alprazolam was not administered to the resident on: - 01/12/2026 at 3:00 PM pending pharmacy by Licensed Practical Nurse #13. - 01/12/2026 at 7:00 PM pending pharmacy by Licensed Practical Nurse #13. - 01/13/2026 at 7:00 AM was not available by Licensed Practical Nurse #52. During an interview on 04/02/2026 at 9:42 AM Licensed Practical Nurse #14 stated the pharmacy was not reliable delivering resident medications and the medications were not always available in the automated medication cabinet. During an interview on 04/02/2026 at 12:40 PM, Licensed Practical Nurse #52 stated when residents returned from the hospital the pharmacy was notified of the readmission and medications were delivered. Resident #14 had alprazolam ordered when they returned to the facility from the hospital. The medication was not available from the pharmacy or in the automated medication cabinet. This was a new pharmacy, and they rarely received medications quickly and had to call the pharmacy frequently. During an interview on 04/03/2026 at 11:29 AM Assistant Director of Nursing #5 stated when residents returned from the hospital orders were reentered into the system. The medication was administered as soon as the pharmacy delivered it. They had deliveries twice a day. There was a complication with getting medications from the pharmacy and from the automated medication cabinet. In January there was a bigger issue with medications being delivered in a timely manner. During an interview on 04/03/2026 at 3:05 PM, the Director of Nursing stated medications should be ordered when there were three (3) or four (4) doses left. The pharmacy was usually quick with the delivery of medications. If they did not have medication for a resident, the nurses should check the emergency medication supply. If the medication was not available there, the physician should be informed to see if there was an alternative. Staff should also call the pharmacy to see when the medication was to be delivered. A progress note should be documented regarding the missed medication and the medical provider being informed. 10 NYCRR 415.18(e)(2)