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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on observations and interviews, the facility failed to ensure each resident had the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States to include sending and receiving mail and to receive letters, packages, and other materials delivered to the facility for all 296 of 296 residents residing in the facility. Specifically, mail was not delivered to residents promptly to include Saturdays.Findings include: The facility policy Resident Mail, last reviewed 9/2025, documented incoming mail would be sorted and distributed daily. The mail was to be given to the resident or placed in a secure location and not opened by staff unless requested or authorized to do so.The facility policy Resident [NAME] of Rights, last reviewed 05/2020, documented residents had the right to send and receive mail promptly and unopened.During an anonymous resident meeting on 03/31/2026 at 3:07 PM, 13 out of 13 anonymous residents stated they only received mail Monday through Friday, and never on Saturdays.During an interview on 04/03/2026 at 10:44 AM, Receptionist #37 stated Mail Clerk #38 was the only one who managed and received the mail in the facility.During an observation and interview on 04/06/2026 at 9:35 AM, Mail Clerk #38 stated they received the mail, separated it by floor into bundles and brought it down to the mail room on the first floor where it is then picked up by the unit clerks to be distributed. They worked Monday through Friday and there was no mail coverage on Saturdays. The receptionist took the mail delivered on Saturdays and locked it up to be picked up on Monday morning. Previously, some receptionists had sorted the mail and distributed it, but they were not supposed to as a lot of errors occurred. They showed the surveyor the cart of mail delivered the previous Saturday they were sorting through to distribute to the units. Residents had previously complained about not receiving their mail on Saturdays. They were aware it was a resident right to receive mail promptly, including on Saturdays.During an interview on 04/06/2026 at 11:59 AM, the Administrator stated on the weekends the receptionist at the front received the mail and the household staff was supposed to come to reception to retrieve it and deliver it to the residents. They were unaware this was not occurring. 10 New York Codes, Rules and Regulations 415.23(e)(2)(i)

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
	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 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)

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 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)

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 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)

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 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)

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observations, record review, and interviews, the facility failed to ensure resident's right to choose activities and health care services consistent with their interests, assessments, and plan of care and the right to participate in social and community activities for two (2) of two (2) residents (Residents #133 and #281) reviewed and for 13 of 13 anonymous residents present at the resident group meeting. Specifically, Residents #133 and #281 and 13 anonymous residents present at the resident group meeting expressed their displeasure with not being able to go outside on facility grounds without supervision.Findings include: The facility policy Resident [NAME] of Rights, last reviewed 05/2020, documented residents had the right to make choices about aspects of their life that were significant to them. The facility would meet their individual needs and preferences to the extent possible, except where health and safety of the residents would be endangered. Residents had the right to participate in the development of their person-centered plan of care. During a resident meeting on 03/31/2026 at 3:07 PM, 13 of 13 anonymous residents stated the facility did not always give them answers regarding their concerns. They felt their rights were not respected by not being able to go outside independently as they were previously able to. They and the staff were not always notified of rules changing in the facility and it led to confusion. Some staff stated residents could not go outside at all and some staff state they could go outside if they stayed right outside the front door. The Resident Council Meeting Minutes documented: - on 11/03/2025 the Administrator reviewed with the residents the new practices put into place which included residents were required to sign out and back in when leaving the household, staff were required to check on the residents who signed off the household every 30 minutes until they returned, and residents were not able to leave the building/go outside unless they were with family or a staff member. - on 12/01/2025 the residents expressed frustration with not being able to go outside by themselves. 2) Resident #133 had diagnoses including diabetes, morbid obesity, and heart failure. The 11/13/2025 Minimum Data Set (a resident assessment tool) documented the resident had intact cognition and felt it was very important to be able to outside to get fresh air when the weather was good. The 02/06/2026 Minimum Data Set documented the resident had intact cognition, used a motorized wheelchair/ scooter, and was independent once seated in their wheelchair/scooter, with ability to wheel at least 150 feet in a corridor or similar space. The Comprehensive Care Plan, initiated 10/31/2024 and revised 02/09/2026, documented the resident was able to independently utilize a personal power vehicle to designated/ supervised areas off the household and throughout the building. They were independent in the pursuit of leisure and social interests. The 01/08/2026 physician order documented the resident was able to independently sit outside when the weather was appropriate. (continued on next page)

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 01/16/2026 physician order documented the resident was able to independently utilize their personal power vehicle to designated/ supervised areas outside. The 02/09/2026 Elopement Risk Assessment documented the resident needed total assistance, had intact cognition, had no elopement attempts, had no behaviors, had no dementia or any type of mental illness, and was not on any mood-altering medications. The resident's elopement risk was low. During an interview on 03/30/2026 at 4:38 PM, Resident #133 in the presence of their family member, stated they loved to be outside when the weather was nice, and they were no longer able to go outside independently. A staff member/ family member/ or friend had to be with them if they went outside. During an interview on 04/03/2026 at 9:14 AM, Certified Nurse Aide #44 stated residents were only allowed to go outside if they had a staff member/ family member/ or friend with them and they needed to sign in and out when leaving the unit. Resident #133 loved to go outside and had a personal power vehicle. The resident was upset they could no longer go outside independently. During an interview on 04/03/2026 at 09:27 AM, Licensed Practical Nurse #45 stated residents could only go outside with a family member or staff and they needed to be signed in and out when leaving the unit. Resident #133 was independent once they were in their personal power vehicle, they loved to go outside and enjoy the nice weather. The resident recently stated to them they missed being able to go outside when the weather was nice. During a telephone interview on 04/03/2026 at 12:22 PM Registered Nurse Neighborhood Manger #46 stated residents were able to go outside but needed to be supervised and had to sign out prior to leaving and sign in when they returned. Residents needed a medical order to go outside and would also need to have a care plan to do so. Resident #133 was independent and could leave the unit, but if they went outside, they required supervision. During an interview on 04/06/2026 at 10:56 AM Social Worker #47 stated residents needed to be supervised if they went outside and had to sign out when they left the unit. The facility changed the outside process in November 2025. They had not offered any support to residents about the changes made regarding going outside. Resident #133 never expressed any concerns regarding not going outside and had just recently transferred to their unit. During an interview on 04/06/2026 at 11:19 AM Social Worker #48 stated residents were not allowed to go outside independently anymore. They need to be near the reception area and within eyesight of staff. They were not aware if residents were offered support or assessed for mood/ behavior changes following the facility change. Resident #133 used to reside on their unit and loved going outside. 3) Resident #281 had diagnoses including kidney disease, diabetes, and insomnia. The 02/10/2026 Minimum Data Set documented the resident was cognitively intact, had no behaviors, was independent for most of their activities of daily living, and used a motorized wheelchair/scooter. The 02/18/2025 comprehensive care plan documented the resident needed encouragement to attend activities of interest related to impaired psychosocial wellbeing related to diagnosis of depression. Interventions included targeting the resident for movies, music, Happy Hour, and outdoor activities when the weather permitted. On 04/02/2026 residents' preferences will be honored for their daily (continued on next page)

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	routine. Interventions included the resident was able to independently utilize their personal power vehicle to designated/supervised areas and they were independent with the use of a scooter style personal protective vehicle and could operate it throughout the health pavilion and on the facility campus. The 11/16/2025 Elopement Risk Assessment documented the resident was fully ambulatory, had intact cognition, had no elopement attempts, had no behaviors, had no dementia or any type of mental illness, and was not on any mood-altering medications. The resident's elopement risk was low. During an interview on 03/30/2026 at 1:15 PM, Resident #281 stated they were previously able to go outside and on the grounds, but they could no longer do that due to one person. They were told it was being worked on, but they did not want to hear it was being worked on anymore, they wanted a solution. They felt locked up in the facility and felt like they were being punished because of one person. Some staff told them they could go as far as the main entrance if they were within eyesight, but other staff would not let them out at all. During an interview on 04/03/2026 at 10:44 AM, Receptionist #37 stated the rule for residents going outside was they could only go outside with family members or facility staff. They were supposed to stop residents from going outside if they were alone. Some residents were unhappy with the new rules. During an interview on 04/03/2026 at 11:57 AM, Certified Nurse Aide #42 stated residents had to sign out of the unit and let staff know they were leaving. Residents were not allowed to go outside independently; only under the supervision of a family member and had to always be with someone. The facility did not have enough staff available to take the residents outside when they wanted. The independent residents were upset about this rule. During an interview on 04/03/2026 at 12:02 PM, Licensed Practical Nurse #43 stated the facility did not have enough staff to take the residents outside and a lot of residents were upset about the rule they could no longer go outside independently. During an interview on 04/06/2026 at 9:19 AM Registered Nurse Neighborhood Manager #12 stated residents were not allowed to go outside independently. The current plan was residents had to be supervised by either family or staff when outside regardless of cognition and mobility level. Independent cognitively intact residents could go all throughout the facility but not outside. Some days they had household attendants who could take residents outside, but some days were better than others for staffing. During an interview on 04/06/2026 at 10:56 AM Social Worker #47 stated residents needed to be supervised if they went outside and had to sign out when they left the unit. The facility changed the outside process back in November 2025. They had not offered any support to residents regarding the changes regarding going outside and had not assessed for mood/ behavior changes following the change. Resident #281 had not complained to them about not being able to go outside, but they knew the resident did enjoy sitting outside. During an interview on 04/06/2026 at 11:59 AM, the Administrator stated residents required a physician's order to go outside independently. Since the cameras were now installed, residents were able to go outside independently into the patio area which was right outside the front door under the supervision of the receptionist, the cameras, and security rounds. Previously residents were not (continued on next page)

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allowed to go outside independently. Family and friends were also allowed to bring residents outside along with facility staff and volunteers to the great lawn for additional outside time. All residents had to be signed in and out of their units, so the facility knew where they were and were allowed to stay out as long as the weather permitted and it was daylight hours. The residents were assessed by the interdisciplinary team to be able to go outside, an order placed, and the information care planned. They received complaints regarding the residents' ability to go outside independently, and they addressed them monthly in resident council. Residents who expressed dissatisfaction or were upset about not being able to go outside anymore were met with individually to address concerns. 10 New York Codes, Rules and Regulations 415.23(b)(1-3)

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for five (5) of eleven (11) medication carts ([NAME], [NAME], Westchester, Manhattan, and Placid Neighborhoods) reviewed. Specifically, the Placid Neighborhood narcotic box contained 30 morphine (opiate) syringes and 57 lorazepam (anti-anxiety) syringes belonging to a deceased resident; the Manhattan Neighborhood medication cart contained one (1) morphine syringe without a resident's name on the label; the Westchester Neighborhood medication cart contained three (3) pre-poured medication cups; the [NAME] Neighborhood medication cart contained expired eye drops and a nasal spray that was not labeled with an open date; and the [NAME] Neighborhood medication cart had expired and undated nasal sprays.Findings included: The facility policy Medication Administration, revised 10/2025, documented controlled medications were placed in the double locked drawer in the medication cart just before medication pass. Nurses ensured the resident was available prior to preparing medications for administration. Expiration dates were checked prior to administration and expired medications were returned to the pharmacy. Expired narcotics must be collected by the Director of Nursing for destruction. The policy did not include directions for collection of medications and narcotics belonging to deceased residents. [NAME] NeighborhoodDuring an observation and interview on 04/02/2026 at 9:42 AM, the top drawer of the medication cart had fluticasone nasal spray with an open date of 01/16/2026 and Afrin nasal spray with an open date of 02/02/2026. Licensed Practical Nurse #14 stated nasal spray should be dated when opened and expired 30 days after being opened. They stated the expired nasal sprays needed to be disposed of and should not have been in the cart. They were not sure why the nasal sprays were still in the cart or why they were not dated when opened. [NAME] NeighborhoodDuring an observation and interview on 04/03/2026 at 12:00 PM, the first drawer of the medication cart had an opened, undated allergy nasal spray. Licensed Practical Nurse #13 stated the nasal spray should be labeled, and they needed to discard it. There were Refresh eye drops opened 12/19/2025 with the instructions to discard after 90 days. Licensed Practical Nurse #13 stated that the eye drops were expired as it was long past 90 days. They were unsure why there was expired or undated medication in the cart as it was not their main neighborhood. They did not check the cart when they started their shift.During an interview on 04/03/2026 at 11:29 AM, Assistant Director of Nursing #5 stated they were supervising the [NAME] and [NAME] neighborhoods, as there was no registered nurse neighborhood manager. Nasal sprays and eye drops were good for 28 days after they were opened and should always be labeled. Consultants came once a month and looked through medication carts to ensure they were accurate. When a resident expired or was discharged their medication should not be kept in the medication cart and should be sent back to the pharmacy on the next medication delivery. Narcotics were gathered for destruction by the Director of Nursing. Nurses called the Director of Nursing and told them they had narcotics that needed to be picked up and they would dispose of them in the pharmacy disposal box. Westchester NeighborhoodDuring an observation and interview on 04/02/2026 at 3:46 PM, the first drawer of the medication cart had three (3) cups of pre-poured medication. Licensed Practical Nurse #32 stated they poured the medications, but the residents were not present in the neighborhood at the time, and they did not want to waste anything. They put the names of the residents on the medication cups, so they did not confuse them. They did not let anyone in their cart, so they knew the residents received the right medications.During an observation and follow-up interview on 04/02/2026 at 3:55 PM, the locked narcotic box contained ten packs of eleven, and one (1) pack of seven (7) morphine syringes belonging to a deceased resident. Licensed Practical Nurse #32 stated the resident passed about a (continued on next page)

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	month ago and they emailed the Director of Nursing to collect the remaining narcotics. When a resident expired or was discharged the Director of Nursing or Assistant Director of Nursing were supposed to come and collect medications. Manhattan NeighborhoodDuring an observation and interview on 04/02/2026 at 4:14 PM, the locked narcotic box within the medication cart had an unlabeled morphine syringe. Licensed Practical Nurse #33 stated they knew who the syringe of morphine was for. They always took the syringe out of the medication bag from the locked narcotic box and put it in the medication cart.During an interview on 04/06/2026 at 9:19 AM, Registered Nurse Neighborhood Manager #12 stated nurses took out of the locked narcotic only the narcotics they needed for the day and placed them into the medication cart. Morphine syringes came in a bag; individual morphine syringes were not labeled, only the bag they came in was labeled. The syringes were not labeled so the whole bag of morphine syringes should have gone in the cart. Placid NeighborhoodDuring an observation and interview on 04/02/2026 at 3:54 PM, the Placid Neighborhood narcotic box contained 57 syringes of lorazepam and 30 syringes of morphine belonging to a resident who expired in January of 2026. Licensed Practical Nurse #11 stated the Director of Nursing came to the neighborhoods to collect medications and dispose of them. Nurses informed the Director of Nursing through voicemail or email that medications were discontinued, expired, or when a resident expired so they could come to the neighborhood and dispose of the medications.During a follow-up interview on 04/06/2026 at 10:10 AM, Registered Nurse Neighborhood Manager #12 stated the Director of Nursing disposed of medications and narcotics. Licensed practical nurses called the Director of Nursing to let them know medications needed to be collected. The nurses continued to count the narcotics when residents were no longer in the neighborhood until they were disposed of by the Director of Nursing. The nurses had emailed the Director of Nursing regarding the narcotics of the expired resident still in the narcotic box.During an interview on 04/03/2026 at 3:05 PM, Director of Nursing #36 stated they were the only person who picked up narcotics that were no longer required. If a resident expired or was discharged , they counted and signed the narcotics out of the logbook and placed them in a double locked box. When that was full, they placed them in a safety box and had it picked up. Narcotics should not be in the neighborhood for a resident that was discharged from the facility in January or February. 10 NYCRR 415.18(d)

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 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, record review, 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 (the 03/30/2026 lunch meal and the 04/01/2026 lunch meal), 13 of 13 anonymous residents during a resident meeting, and one (1) resident (Resident #11) reviewed. Specifically, food was not served at palatable and appetizing temperatures during lunch meals on 03/30/2026 and 04/01/2026; 13 anonymous residents during a resident council and Resident #11 stated the food was cold. Additionally, multiple meal trays were observed sitting for 30-60 minutes prior to resident consumption; and the facility did not have a procedure in place to ensure food was properly re-heated on the resident units to the required temperatures. Findings include: The facility policy Taste and Temperature Control, revised 05/2023, documented cold food such as milk, juice, and ice cream, should be refrigerated or on ice during meal service to maintain proper temperature. There was no documentation regarding appropriate temperatures of foods when served to the residents.During an observation on 03/30/2026 at 11:47 AM, Resident #19's lunch meal was tested, and a replacement meal was ordered. Food temperatures were measured and verified by Certified Nurse Aide #15 as follows: roasted sweet potatoes were 129.6 degrees Fahrenheit, apple crisp was 51.6 degrees Fahrenheit, cranberry juice was 52.2 degrees Fahrenheit. The apple crisp was bland with hard apples, and the cranberry juice tasted lukewarm. During an interview on 03/30/2026 at 12:30 PM, Resident #11 stated the food was often cold.During an observation and interview on 03/30/2026 at 2:11 PM Residents #205 and #206 were out of the budling for the lunch meal and their meal trays were sitting on a table in the dining room The trays contained potentially hazardous foods, including roasted turkey breast and milk. Licensed Practical Nurse #16 stated they left the trays out for the residents and would serve the trays to them when they returned to the facility. During an observation on 04/01/2026 at 12:37 PM, Resident #235's lunch meal was tested. The resident was out of the building. Food temperatures were measured and verified by Licensed Practical Nurse #18 as follows: pork loin was 135.2 degrees Fahrenheit, bread stuffing was 134.2 degrees Fahrenheit, chocolate milkshake 56.7 degrees Fahrenheit, water 54 degrees Fahrenheit. The pork loin was very hard to chew, and the milkshake tasted lukewarmDuring a continuous observation on 04/02/2026 between 8:00 AM and 12:00 PM: -at 8:29 AM, Food Service Worker #8 started passing breakfast trays. Four (4) residents were in the dining room and were served, including Resident #15. The doors to the cart were left open and the remaining resident trays were left in the cart;-at 8:50 AM, many residents were still in bed. Licensed Practical Nurse #35 stated they usually came out to the dining room by 9:00 AM. The food cart was sitting with the doors open, and seven trays were still in cart;-at 9:01 AM, Certified Nurse Aide #15 re-heated the pancakes for Resident #15 and assisted them with their meal. There was no evidence the temperature of the food was checked after being reheated. -at 9:11 AM, six (6) breakfast trays remained in the meal cart with the doors open and untouched; -at 9:24 AM, Residents #39 and #235 came into the dining room and were served their breakfast meal from the open cart without re-heating the food. Resident #39 requested their meal be heated up and Certified Nurse Aide #17 put the plate in the microwave for 30 seconds There was no evidence the temperature of the food was checked after being reheated. Resident #235 ate their breakfast meal without staff re-heating it.-at 9:52 AM, three (3) breakfast trays were unpassed and left in the meal cart with the door opened. The milk carton on one tray and a milkshake on another tray felt warm to touch. Certified Nurse Aide #19 pulled the meal trays out of the cart and set them out on the counter and stated they were going to serve them to the residents if they got up to eat. -at 10:00 AM Resident #280 entered the dining room and Certified Nurse Aide #19 heated up pancakes for the resident. There was no evidence the temperature of the food was checked after being reheated. -at 11:45 AM, three resident trays remained on the counter untouched. The residents were still in bed at that time.During an interview on 04/02/2026 at 9:35 AM, Certified Nurse Aide #17 stated there was no formal procedure to re-heat (continued on next page)

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meal trays. They reheated the resident's meal trays in the microwave at 30 second intervals until the plate felt warm. They did not have a thermometer on the unit to check the temperature of the food.During an interview on 04/02/2026 at 10:05 AM, Certified Nurse Aide #19 stated there was no formal procedure to re-heat meal trays. They reheated the resident's meal trays in microwave at 30 second intervals until the plate felt warm. They did not have a thermometer on the unit to check the temperature of the food and did not know what temperature food should be reheated to. Hard boiled eggs and dairy items should not be served to the residents if they were left in an open meal cart for almost two hours. If residents were sleeping during meal service nursing staff did not wake them up. During an interview on 04/02/2026 at 10:15 AM, Licensed Practical Nurse #35 stated they re-heated resident's meal trays for 30 seconds and did not know what temperature to heat the food items to. There was no thermometer on the unit to check the temperature of the food once it was reheated. Eggs and milk should not be left out at room temperature for two hours. During an interview on 04/03/2026 at 9:52 AM Certified Nurse Aide #20 stated nursing staff assisted the residents with their meals. Food items stayed hot for one (1) hour, after one (1) hour they reheated the food and served the residents. There was no formal procedure on how to re-heat meal trays. They put the plate in the microwave for 30 second intervals until the plate felt warm. They did not have a thermometer on the unit to check the temperature of the food. Meal trays that sat on the counter were discarded if the resident refused the meal. Unconsumed breakfast trays should not be left out on the counter at 11:45 AM. During an interview on 04/03/2026 at 10:31 AM, Food Service Director #6 stated food service staff delivered the meal carts to the units and passed out the meal trays in the dining room. They did not deliver meal trays to the resident's rooms if a resident was sleeping to prevent the meal trays from getting cold while they slept. Food service staff removed unconsumed trays out of the meal cart and placed them on the counter in the kitchenette. Meal trays should be served within one (1) hour from the start of the meal. They were unsure how long the plate warming base kept the food warm. Meal trays containing meat and eggs should not be left sitting in the meal cart or on the counter for over two (2) hours. The units all had a thermometer to test the temperatures of the food after staff reheated the meal trays. Breakfast meal trays should not be left sitting out on the counter at 11:45 AM, because the food had been in the temperature danger zone too long. They did not know what the process was for reheating food on the units. The nurse educator educated the nursing staff on how to reheat food in the microwave and what the temperature food items should be heated to. During an interview on 04/03/2026 at 11:10 AM, Registered Nurse #29 stated food service staff brought the breakfast meal trays to the unit around 8:25 AM, and passed out all the trays, including room trays. They held any unconsumed meal trays for residents in case they want them later. The meal trays could be served for one (1) hour after the meal cart arrived on the unit. After one (1) hour the food needed to be reheated in the microwave for one (1) minute. Any unconsumed breakfast meal trays should not sit out on counter until 11:45 AM. During an interview on 04/06/2026 at 9:23 AM, Licensed Practical Nurse #18 stated they were not sure of the official process, but thought food service staff served the meal trays to all residents and nursing staff assisted the residents with eating. They thought the meal trays could be served up to 75 minutes from when they arrived on the unit. Meal trays that were on the counter should be taken back to the kitchen if unconsumed. Meal trays containing meat and dairy that were on the counter past 75 minutes should not be served. 10 New York Codes, Rules and Regulations 415.14(d)(1)(2)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure proper sanitation and food handling practices to prevent the outbreak of foodborne illness in one (1) of one (1) main kitchen. Specifically, the main kitchen had unlabeled/undated prepared and leftover food; and dishwashing machine temperatures were not monitored routinely. Findings include:The facility policy Mechanical Wear (ware) washing, revised 05/2023, documented warewashing temperatures would be taken and recorded in the supervisor monitoring log during each meal period. Food Storage During an observation and interview on 03/30/2026 at 9:56 AM, the following was observed in the main kitchen:-two pans of prepared and cooked food in the reach-in cooler, identified by Food Service Director #6 as leftover hashbrowns and ground chicken, were not labeled or dated; -one pan of prepared and cooked food in the walk-in cooler, identified by Food Service Director #6 as leftover kielbasa, was not covered, labeled, or dated; -three pans of prepared and cooked food in the walk-in cooler, identified by Food Service Director #6 as leftover fish, cooked beef, and garlic bread, were not labeled or dated. Dinnerware Sanitization and Storage During an observation and interview on 04/01/2026 at 11:09 AM, the Weekly High Temperature Mechanical Warewashing Log was reviewed for March 2026, and the following entries were missing:-03/01/2026: Breakfast, Lunch, and Dinner;-03/02/2026: Breakfast, Lunch;-03/03/2026: Breakfast, Lunch, and Dinner;-03/04/2026: Lunch;-03/05/2026: Breakfast, Lunch;-03/06/2026: Breakfast, Lunch;-03/09/2026: Breakfast, Lunch;-03/10/2026: Breakfast, Lunch;-03/11/2026: Breakfast, Lunch;-03/12/2026: Breakfast, Lunch;-03/13/2026: Breakfast, Lunch, and Dinner;-03/14/2026: Breakfast, Lunch, and Dinner;-03/15/2026: Breakfast, Lunch, and Dinner;-03/16/2026: Breakfast, Lunch;-03/17/2026: Breakfast, Lunch;-03/18/2026: Breakfast, Lunch;-03/19/2026: Breakfast, Lunch, and Dinner;-03/20/2026: Breakfast, Lunch;-03/21/2026: Breakfast, Lunch;-03/22/2026: Breakfast, Lunch;-03/23/2026: Breakfast, Lunch;-03/24/2026: Breakfast, Lunch;-03/25/2026: Breakfast, Lunch;-03/26/2026: Breakfast, Lunch;-03/27/2026: Breakfast, Lunch;-03/28/2026: Breakfast, Lunch, and Dinner;-03/29/2026: Breakfast, Lunch, and Dinner;-03/30/2026: Breakfast, Lunch, and Dinner;-03/31/2026: Breakfast, Lunch, and Dinner.During an interview on 04/01/2026 at 11:30 AM, Food Service Director #6 stated the dish machine temperatures were recorded three times a day at mealtimes by a kitchen supervisor and recorded on the Weekly High Temperature Mechanical Warewashing Log. The missing temperatures were a concern, and they were unsure why so many were missing. The dish machine temperatures were monitored to ensure dishes were sanitized properly. Prepared and cooked food should be covered in the cooler to prevent contamination and should be labeled and dated to identify what the food was and when it needed to be used or discarded by.During an interview on 04/01/2026 at 11:51 AM, [NAME] #7 stated they worked in the kitchen at the facility for over a year. They stated leftover prepared and cooked food was sealed in a bag or container and labeled and dated prior to going in the refrigerator. The food should be covered to prevent contamination and labeled and dated to identify what the food was and to ensure the oldest product was used first. 10 NYCRR 415.14(h)

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 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)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review the facility failed to ensure the interdisciplinary team determined a resident's ability to safely administer their own medications, if clinically appropriate, for one (1) of one (1) resident (Resident #299) reviewed. Specifically, Resident #299 had a large bottle of acetaminophen (pain reliever), a tube of Neosporin (antibiotic ointment), a bottle of antacids, loperamide gel capsule (antidiarrhea medication), and a medication cup with several different pills in their room. There was no documented evidence of assessments and/or physician orders for the resident to safely self-administer medications. Findings included:The facility policy Medication Administration, revised 10/2025, documented nurses were to remain with the resident until medications were swallowed. They were not to leave medication with the resident to be taken later unless it was ordered by medical and care planned. The facility policy Self-Administration of Medication Program, last reviewed 12/2025, documented if a resident requested to self-administer medications an assessment would be completed and reviewed by the interdisciplinary team. The interdisciplinary team determines if self-administration was clinically appropriate for the resident and would document it in the medical record and on the resident's care plan. A physician's order was needed prior to the initiation of a self-administration program specifying the specific medications the resident was to be self-administrating. The interdisciplinary team will re-evaluate the self-administration program on a quarterly basis, with any significant changes and as needed to ensure it is clinically appropriate. Resident #299 had diagnoses including dementia, left sided weakness following a stroke, and anxiety. The 01/03/2026 Minimum Data Set documented the resident had intact cognition and required set up or was independent for most activities of daily living. There was no documented evidence of a comprehensive care plan related to self-administration or storage of medication in their room. There was no documented evidence of a medication self-administration assessment or a physician order for self-medication. The resident was observed on:- 03/30/2026 at 11:10 AM sitting in their rocking recliner in their room watching television. There was a tube of Neosporin with their name and a bottle of antacid on the overbed table and a large bottle of acetaminophen on their nightstand.- 03/31/2026 at 2:19 PM asleep in their recliner chair. There was a bottle of antacid on their over bed table next and a large bottle of acetaminophen on their nightstand. During an observation and interview on 04/01/2026 at 9:07 AM, the resident was sitting in the recliner chair. There was a bottle of acetaminophen on their nightstand. There was a bottle of antacid, a small blue gel pill (loperamide) sealed in cut up packaging, and a medicine cup with several unidentified pills on their overbed table. The medicine cup contained two (2) small white pills, one (1) oblong tan pill, one (1) large oblong white pill, one (1) yellow gel pill, one (1) light orange round pill, one (1) pink smaller oblong pill, one (1) half white pill, and one (1) small round pill. The resident stated there should be about nine (9) pills in the medicine cup which included a blood thinner and a seizure pill. The resident stated they believed the small blue pill in the packaging was loperamide their adult child brought to them, but they were not sure. They stated they took the antacids if their stomach was bothering them or if they had heartburn. They had sneaked the acetaminophen in, but they did not take it very often, only when they had headaches. The medication cup was left by the nurse that morning because they did not like to take the medications on an empty stomach, so they waited to take them until they had a few bites to eat. During an interview on 04/01/2026 at 9:22 AM, Licensed Practical Nurse #49 stated they only occasionally left medications with two residents. Resident #299 did not have an order for their medications to be left at bedside but when they sat with the resident waiting for them to take the medications, the resident would not take them, so they left the medications in the room. They stated the resident did well with taking their medications after they had a little bit of food, as taking them on an empty stomach made the resident sick, so they left the resident with the medications so they could eat first. They were unaware of the bottle of antacids, acetaminophen, and loperamide gel capsule in the resident's room. They stated the resident had an (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for acetaminophen three times a day so they should not need more. The resident did not have an order for loperamide. They stated the resident's family probably brought the medications in for them. During an interview on 04/03/2026 at 2:00 PM, Registered Nurse Neighborhood Manager #50 stated medications should not be left at a resident's bedside unless they were care planned that way. The nurse should watch the resident to make sure the medication was administered. The nurse should not leave medications at the resident's bedside even if the resident was taking a lot of time to take their medications. Resident #299 was not assessed for a medication self-administration program. The resident should not have personal over the counter or nurse administered medications at their bedside. 10 New York Codes, Rules and Regulations 415.23(f)(1)(vi)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to include services provided to maintain the resident's highest practicable physical well-being for two (2) of two (2) residents (Residents #77 and #16) reviewed. Specifically, Resident #77's person-centered comprehensive care plan did not include the use of oxygen; and Resident #16's person-centered comprehensive care plan did not include the use of psychotropic (used to treat mood/ behaviors) medications.Findings include:The facility policy Interdisciplinary Comprehensive Care Plans, revised 09/2025, documented a person-centered care plan would be developed by the interdisciplinary care team to ensure services were being provided to assist the resident in achieving/maintaining their highest practicable physical, mental, and psychosocial wellbeing. The person-centered Interdisciplinary care plan would be completed in conjunction with the medical data set assessment by day fourteen from admission and would be reviewed and revised quarterly, annually, and as needed. 1) Resident #77 had diagnoses including pneumonia, respiratory failure with hypoxia (low levels of oxygen in body tissues), and pulmonary hypertension (high blood pressure in the arteries of the lungs). The 03/04/2026 Minimum Data Set (a resident assessment tool) documented the resident had intact cognition; had shortness of breath with exertion and while lying flat; and was on continuous oxygen therapy. The 03/03/2026 physician order documented oxygen at four (4) liters/minute continuous by nasal cannula (tube in nose). There was no documented evidence the comprehensive care plan included an individualized respiratory care plan with the use of oxygen. The resident profile (care instructions) did not include the use of oxygen. During an interview on 04/06/2026 at 10:26 AM, Certified Nurse Aide #9 stated they were unsure if oxygen use should be included in the care plan but thought it should so they would know if Resident #77 was supposed to use oxygen continuously or as needed and to monitor and ensure the resident was using it as ordered. During an interview on 04/06/2026 at 10:31 AM, Licensed Practical Nurse #3 stated registered nurses were responsible for initiating and updating care plans. Resident #77 used oxygen continuously since admission. They thought oxygen should be included in the care plan, so staff knew how many liters per minute the resident was on, if the resident required continuous or as needed oxygen, to monitor the resident's breathing, and to ensure the resident was wearing and receiving oxygen as ordered. During an interview on 04/06/2025 at 10:42 AM, Registered Nurse/Charge Nurse #10 stated registered nurses were responsible for initiating and updating resident care plans and the care plan should include everything about the resident's care. Resident #77 should have oxygen therapy on their care plan, so staff knew how many liters per minute were ordered, if the resident needed continuous or as needed oxygen, when to check the resident's oxygen levels, and to monitor for shortness of breath or other respiratory issues. 2) Resident #16 had diagnoses including Alzheimer's disease and adult failure to thrive (overall (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical decline). The 02/14/2026 Minimum Data Set (resident assessment tool) documented the resident had severely impaired cognition; had no depressive symptoms or behaviors; had no psychiatric/mood disorders; and received both an antipsychotic and an antidepressant with an indication noted. The Care Area Assessment Summary documented psychotropic drug use was triggered, and care planning was necessary. The 10/14/2025 physician order documented 0.5 milligram tablet of risperidone (antipsychotic) by mouth two times a day for dementia with anxiety. The 11/02/2025 physician order documented 25 milligram tablet of sertraline (an antidepressant) once a day for dementia with anxiety. There was no documented evidence of a care plan related to the resident's psychotropic medication use or interventions for any history of behaviors and depression The 03/06/2206 Physician #41 progress note the resident had advanced major neurocognitive disorder likely a mixed type of vascular and Alzheimer's type. The resident was started on risperidone as well as sertraline to help with their mood and anxiety. The resident recently had been much better with their behaviors. The 03/16/2026 Nurse Practitioner #40 Psychiatric Consultation documented the resident was seen for an initial evaluation due to their anxiety by facility staff request. The resident had outpatient behavioral health services in the past. The recommendations were to continue the risperidone 0.5 milligram tablet twice a day for agitation from dementia and the sertraline 25 milligram tablet once a day for depression and anxiety. Staff were to reinforce coping skills and non-pharmacological measures and monitor changes in mood, behaviors, and medication side effects. There was no documented evidence of a care plan addressing the resident's anxiety and use of non-pharmacological measures. During an interview on 04/03/2026 at 10:15 AM, Certified Nurse Aide #26 stated behaviors were documented on the care plan, but they were unsure if interventions for behaviors were also there. Resident #16 had behavioral symptoms which included hitting/swinging out at staff and verbal aggression. The resident became agitated when they were in bed or asleep and pulled the soft boots, socks, and bandages off their feet and blankets off their body. The resident had swung at them this morning. They tried to approach Resident #16 calmly and if that did not work, and the resident was in a safe position, they left the resident alone and documented on it. During an interview on 04/03/2026 at 10:59 AM, Licensed Practical Nurse #27 stated behavioral interventions should be listed on the resident's care plan. Resident #16 had verbally aggressive behaviors. When Resident #16 had verbally aggressive behaviors, they left the resident alone to calm down and then reapproached. During an interview on 04/03/2026 at 2:16 PM, Registered Nurse Neighborhood Manager #29 stated care plans were an interdisciplinary team effort, but psychotropic and behavior care plans were done by them. Psychotropic medications should be addressed on the resident's comprehensive care plan. Resident #16 should have a care plan addressing their sertraline and risperidone use. The resident had behaviors in the past, but they were not aware of any recent behaviors. Recurrent behaviors should be addressed on the resident's care plan. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Codes, Rules and Regulations 415.23(c)(1)

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 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. Based on observations, record review, and interviews, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and promote healing of pressure ulcers for two (2) of five (5) residents (Residents #16 and #304) reviewed. Specifically, Resident #16's and Resident #304's pressure relieving interventions were not implemented as planned; and Resident #16 had conflicting wound care orders signed off as completed and wound care recommendations by the wound care provider were not implemented. Findings include: The facility policy Skin and Wound Care Policy and Procedure, reviewed 8/2025, documented the facility established a comprehensive, interdisciplinary approach for prevention, assessment, treatment, and monitoring of all wound types. Certified Nurse Aides were responsible for floating heels and managing offloading devices per the resident's care plan. The licensed practical nurses were responsible for implementing wound and prevention orders, performing ordered dressing changes within scope, and documenting wound observations. Registered nurses/Wound Nurse was responsible for initiating individualized interventions and obtain provider orders for treatment, recommended diagnostics, and consults. 1) Resident #16 had diagnoses including Alzheimer's disease and adult failure to thrive (overall physical decline). The 02/14/2026 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition; required maximum assistance or was dependent for most activities of daily living; was at risk of developing pressure ulcers; had a Stage 4 pressure ulcer (full thickness tissue loss with exposed tendon or muscle) and two (2) unstageable (full thickness tissue loss in which the base of the ulcer is covered by dead tissue) pressure ulcers with one (1) presenting as a deep tissue injury (purple/maroon localized area of discolored intact skin due to underlying tissue damage); had pressure reducing devices to the bed and chair; and had wound care and applications of dressings to their feet. The 02/25/2026 Comprehensive Care Plan, revised 03/11/2026, documented the resident was at high risk for skin breakdown. Interventions included to wear Prevalon boots (cushioned boots that alleviate pressure) while in bed. Physician orders documented the following: -10/13/2025 offload heels at all times and wear Prevalon boots in bed. -01/23/2026 apply Betadine (an antiseptic) to the left heel twice a day and leave open to air. -01/30/2026 apply Betadine to the right heel unstageable ulcer, apply heel cup (protective covering), cover with dry gauze and kerlix and change daily. -02/01/2026 apply Betadine 10% topical solution to bilateral heel ulcers, cover with dry gauze and kerlix and change daily. The 3/20/2026 Nurse Practitioner #22 Wound Care Follow Up Note documented the resident had a Stage 4 pressure injury and bilateral heel unstageable pressure injuries. The treatment history outline documented: (continued on next page)

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 02/06/2026 and 02/13/2026 nursing staff were to apply Betadine and a dry dressing to both heels, secure the dressing with kerlix. Heel cups were not to be used as the gauze bunching under the foam may cause a skin injury. -on 03/06/2026 and 3/20/2026 nursing staff were to continue with the current plan. The left heel was to be painted with Betadine and left open to air. The right heel was to have the eschars (dead tissue) painted with Betadine then apply Betadine moistened gauze over the area and secure with kerlix (cotton rolled dressing). Foam heel cups were to be used, and the dressings changed daily. There was no documented evidence the 3/6/2026 and 3/20/2026 Nurse Practitioner #22's recommendations for right heel to have the eschar painted with Betadine then apply Betadine moistened gauze over the area and secure with kerlix was implemented. The 04/03/2026 Nurse Practitioner #22 progress note documented the resident's treatments to their heels were to paint the left heel with Betadine and leave open to air. The right heel eschar was to be painted with Betadine, apply dry gauze, secure with kerlix. The dressing was to be changed daily, and staff could continue to use foam heel cups. The March 2026 and April 2026 Treatment Administration Records documented the following orders as completed: -01/23/2026 apply Betadine (an antiseptic) to the left heel twice a day and leave open to air. -01/30/2026 apply Betadine to the right heel unstageable ulcer, apply heel cup (protective covering), cover with dry gauze and kerlix and change daily. -02/01/2026 apply Betadine 10% topical solution to bilateral heel ulcers, cover with dry gauze and kerlix and change daily. The orders to cover bilateral heels ulcers with dry gauze and kerlix conflicted with the order to apply betadine to the left heel and leave open to air. The March 2026 and April 2026 Treatment Administration Records documented the 01/23/2026 left heel wound care order, the 01/30/2026 right heel wound care order and the 02/01/2026 bilateral heel order were all signed as completed. The March 2026 and April 2026 Treatment Administration Records documented the order to offload the resident's heels at all times with Prevalon boots in bed was signed as completed every shift except for the nightshift on 03/05/2026 and dayshift on 03/29/2026 when there was no documentation and the dayshift of 03/19/2026 and the nightshift of 03/30/2026 when the resident was out of bed. The resident was observed on: - 03/31/2026 at 2:46 PM, asleep in bed not wearing Prevalon boots. The Prevalon boots were on top of a basket. - 04/01/2026 at 11:35 AM and 2:27 PM, asleep in bed on their left side not wearing Prevalon boots. The Prevalon boots were on top of a basket. (continued on next page)

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/01/2026 at 2:30 PM, Certified Nurse Aide #26 stated if a resident was supposed to be wearing offloading boots in bed it was documented in the resident's chart. They stated Resident #16's family did not want the resident wearing the offloading boots because the resident refused to wear them as they made the resident uncomfortable. Resident #16 became agitated and would take off the offloading boots and the bandages on their foot. The staff on the unit and the nurse manager know the resident's family stated not to put the boots on the resident. During an interview on 04/02/2026 at 2:48 PM, Licensed Practical Nurse #28 stated residents who should wear Prevalon boots in bed had orders on their Treatment Administration Record. They did not know if Resident #16 had orders for Prevalon boots while in bed. The order on the Treatment Administration Record was meant to make the nurse aware of the boots needing to be on the resident and signing off on the order meant the nurse knew of the order. The Treatment Administration Record listed all wound treatment orders. They followed the individual heel orders for Resident #16; leaving the left heel open to air after Betadine and wrapping the right heel after Betadine with heel cup in place. The orders needed to be fixed as sometimes they were confusing. During an interview on 04/03/2026 at 10:59 AM, Licensed Practical Nurse #27 stated if a resident was supposed to have Prevalon boots on in bed it should be on their Treatment Administration Record. When the order was signed off as completed it meant the nurse had verified the certified nurse aide put the boots on the resident. Resident #16 did not wear their Prevalon boots because they did not like anything on their feet. On 04/01/2026 the resident was not wearing their Prevalon boots. Licensed Practical Nurse #27 stated they did not remember signing off on the Treatment Administration Record the resident was wearing their boots on 04/01/2026 but it was one of those things that was just a click of a button. During an interview on 04/03/2026 at 2:16 PM, Registered Nurse Neighborhood Manager #29 stated Resident #16 was care planned to wear Prevalon boots in bed, but they refused them. They were not aware the resident's refusals were not being documented. The licensed nursing staff should not be signing off the Prevalon boots order as completed if the resident refused to wear them. The resident should have their refusals of the boots care planned and the provider should have been notified. They were unaware Resident #16's family did not want the resident wearing the Prevalon boots since they agitated the resident. Wound care orders were entered by the neighborhood managers in the past, but Registered Nurse #30 assisted with wound rounds and placing the orders. The wound care orders should match the recommendations made by the wound care nurse practitioner. If there were conflicting orders for wound care the licensed nursing staff should contact the provider and find out which orders were correct, and they should not sign off all the orders as completed. They were unaware Resident #16 had multiple orders for the heel wounds and stated the previous orders must not have discontinued when new ones were ordered. During an interview on 04/06/2026 at 9:53 AM, Registered Nurse #30 stated they put in the wound care orders from wound rounds. The wound care orders should match the recommendations of the Wound Care Nurse Practitioner. They only discontinued the previous orders if the Wound Care Nurse Practitioner's new orders indicated to do so. If the previous order was put in by a different provider than the Wound Care Nurse Practitioner, they did not discontinue the previous orders. During an interview on 04/06/2026 at 10:55 AM, Wound Care Nurse Practitioner #22 stated they expected the facility to follow their recommendations for wound care orders. Old wound care orders should be discontinued when new orders were entered. Resident #16 should have the order for the bilateral heels discontinued as both heels had an individual treatment. They were just made aware on (continued on next page)

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/03/2026 Resident #16 was not wearing their Prevalon boots while in bed. The resident should have an order for the Betadine moistened gauze to the right heel as that was their treatment recommendation prior to when they saw the resident on 04/03/2026. 2) Resident #304 had diagnoses including Alzheimer's disease, adult failure to thrive (overall physical decline), and history of venous thrombosis and embolism (formation of blood clots). The 07/19/2026 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, did not refuse care, required substantial assistance for most activities of daily living and transfers, and was at risk for developing pressure ulcers. The 08/23/2024 Comprehensive Care Plan, revised 07/21/2025, documented the resident had a skin condition following a deep vein thrombosis. Interventions included frequent repositioning. On 01/25/2026 the care plan was updated and documented the resident was at a mild risk for skin breakdown. Interventions included refer to basic needs and preferences for cushions, positioning devices, specialty mattresses, and lifting devices. The 03/14/2025 physician order documented Spenco boots (pressure relieving boots) while in bed. The 08/19/2025 care card (care instructions) documented the resident had Spenco boots while in bed. The March 2026 Treatment Administration Records documented Spenco boots on while in bed and was signed off as completed every shift. The following observations were made of Resident #304: - on 03/30/2026 at 2:07 PM, asleep in bed, lying flat on their back. The resident was not wearing Spenco boots. The Spenco boots were on their recliner. - on 03/31/2026 at 4:06 PM, the resident was lying in bed flat on their back. The resident was not wearing Spenco boots. The Spenco boots were on their recliner. During an interview on 04/02/2026 at 2:03 PM, Licensed Practical Nurse #14 stated Resident #304 was at risk of developing pressure injuries and should wear pressure relieving boots every time they were in bed. It was the responsibility of the certified nurse aide who put the resident to bed to ensure they were placed on the resident. Certified Nurse Aide #51 was assigned to Resident #304 on 03/30/2026 and 03/31/2026. During an interview on 04/02/2026 at 3:01 PM, Certified Nurse Aide #51 stated pressure relieving boots were an intervention to reduce the risk of pressure injuries. Resident #304 did have pressure relieving boots and did not refuse care. They stated they put the resident back to bed on 03/30/2026 and 03/31/2026 but did not remember if they placed the boots on the resident. During an interview on 04/03/2026 at 11:29 AM, Assistant Director of Nursing #5 stated pressure relieving boots were an intervention utilized to reduce the risk of developing pressure injuries. If pressure relieving boots were ordered, were on the resident's care plan, or on the certified nurse aide care instructions, they expected the boots to be placed on the resident when they were in bed. 10 New York Codes, Rules, and Regulations 415.12(c)(1)

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, record review and interviews, the facility failed to ensure residents who were fed by enteral means (tube feeding, delivery of nutrition directly to the stomach or small intestine) received the appropriate treatment and services to prevent complications of enteral feeding for one (1) of one (1) resident (Resident #4) reviewed. Specifically, Resident #4's hung tube feeding was not dated during multiple observations.Findings include: The facility policy Gravity, Tube Feeding, Enteral, Gastrostomy, or Jejunostomy, revised 06/2023 did not document dating and timing of tube feedings when administered. The manufacturer details for Nepro tube feeding formula, last updated 2025, documented unless a shorter hang time is specified by the set manufacturer, hang product for up to 48 hours after initial connection when clean techniques and only one new set are used. Otherwise hang for no more than 24 hours. Resident #4 had diagnoses including dysphagia (difficulty swallowing), chronic kidney disease, and cerebral infarction (stroke). The 02/27/2026, Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, did not eat by mouth, weighed 196 pounds, and received nutrition through a feeding tube.Physician orders documented:-03/18/2025 nothing by mouth, may have popsicles.-12/09/2025 hold tube feeding from 05:00 AM and restart at 07:30 AM.-12/17/2025 provide Nepro (tube feeding formula) at 45 milliliters an hour for 21.5 hours for total volume of 967.5 milliliters daily via gastrostomy tube (a feeding tube inserted through the abdomen into the stomach). The March 2026 Medication Administration Record documented Nepro at 45 milliliters an hours for 21.5 hours for a total daily volume of 967.5 milliliters.The following observations were made:-on 03/31/2026 at 8:42 AM and 4:00 PM, the resident was in their recliner chair seated upright. Their tube feeding pump was on and functioning. The pump indicated the tube feeding was infusing at 45 milliliters per hour. There was no documented evidence of the day/ time the tube feeding was opened and hung.-on 04/01/2026 at 9:18 AM, the resident was in bed with the head of the bed positioned greater than 30 degrees. Their tube feeding pump was on and functioning. The pump indicated the tube feeding was infusing at 45 milliliters per hour. There was no documented evidence of the day/ time the tube feeding was opened and hung.During an interview on 04/01/2026 at 12:20 PM Licensed Practical Nurse #39 stated tube feedings should be dated when hung. Resident #4's tube was on hung on the evening shift. They had not noticed it was not dated but checked to make sure the correct formula was hung, and it was infusing during their shift. Tube feedings should be dated so staff knew how long it was hung for, as it was only supposed to be hung for 24 hours.During an interview on 04/01/2026 at 12:41 PM Registered Nurse Neighborhood Manager #12 stated the nurse who hung the tube feeding should date it, so staff knew when it was hung.During a telephone interview on 04/01/2026 at 1:26 PM Licensed Practical Nurse #11 stated Resident #4's tube feeding was hung on the evening shift as it ran for 21.5 hours. They should date the tube feeding when it was hung, but they were terrible with dating, they were busy and did not think about it. 10 New York Codes, Rules and Regulations 415.12(g)(2)

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 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 one (1) of one (1) resident (Resident #312) reviewed. Specifically, Food Service Worker #2 entered Resident #312's room, who was on enteric precautions (measures to prevent the spread of pathogens transmitted through feces), without donning personal protective equipment or performing hand hygiene upon exit. Findings included:The facility policy Transmission Based Precautions, last reviewed 11/2025, documented it was the responsibility of all personnel who had direct contact with residents to follow transmission-based precautions. Enteric precautions were contact precautions specifically for difficult to treat infections such as clostridium difficile, enterohemorrhagic Escherichia coli (severe intestinal infection), shigella (contagious intestinal infection), hepatitis A, or rotavirus (a highly contagious virus). Contact precautions required the use of gowns and gloves on every person entering the resident's room. A brown enteric precaution sign was placed outside the resident's room with personal protective equipment available. All staff were to wash hands with soap and water or use hand sanitizer before donning gloves. Staff were to wear gowns and gloves when entering the resident's room. Prior to leaving the room staff were to remove their gown and gloves and perform hand hygiene with soap and water.Resident #312 had diagnoses including enterocolitis (inflammation of intestines) due to clostridium difficile (a highly contagious bacteria) and diarrhea. The 03/26/2026 Minimum Data Set (a resident assessment tool) documented the resident had enterocolitis due to clostridium difficile.The 03/23/2026 Care Plan documented the resident had a clostridium difficile infection. Interventions included to maintain enteric contact precautions for the remainder of the infection.The 03/20/2026 physician order documented the resident was on enteric precautions.During an observation on 03/30/2026 at 11:42 AM, Resident #312's room had an enteric precaution sign outside the door. Food Service Worker #2 entered the resident's room to deliver their lunch tray without removing their gloves worn in a different residents' room. Food Service Worker #2 did not perform hand hygiene or put on a gown and new gloves. While in the room they moved the resident's wheelchair out of the way and pulled the over bed table closer to the resident's lap for lunch. Food Service Worker #2 left the room without removing gloves or performing hand hygiene.During an interview on 03/30/2026 at 11:47 AM, Food Service Worker #2 stated they did not know when residents were on precautions or what that meant. After looking at the enteric precaution sign they stated they did not know what the sign meant or what information it provided. When they brought food carts to units, they washed their hands and donned gloves before entering the unit. They did not remove their gloves until they finished passing out all meal trays. Just before they left the unit, they removed their gloves and used hand sanitizer. They did not remember if they had education on infection control or transmission-based precautions.During an interview on 04/03/2026 at 11:29 AM, Assistant Director of Nursing #5 stated they were the Infection Prevention nurse for the facility. Different types of precautions included enhanced barrier, contact, droplet, airborne, and enteric. Enteric precautions were mostly for clostridium difficile infection or any infection where alcohol-based products were not effective. It was required by all staff who entered a resident's room on enteric precautions to perform hand hygiene, don a gown and gloves before entering the room, remove gown and gloves before exiting the room, and perform hand hygiene with soap and water inside the room. Food service workers were required to wear personal protective equipment when entering an enteric precaution room. The same pair of gloves should not be worn when moving between resident rooms.During an interview on 04/03/2026 at 2:51 PM, Certified Nurse Aide #4 stated when residents were on transmission-based precautions there was a sign outside their door which told them what kind of precaution it was. Enteric precautions were for someone who had an infection or a catheter. The sign told staff what personal protective equipment to wear. The infection (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention nurse hung the signs and told us what type of precautions residents were on.During an interview on 04/03/2026 at 2:58 PM, Licensed Practical Nurse #3 stated staff knew when residents were on precautions because there were a sign and personal protective equipment outside their room. Enteric precautions were used for residents who had catheters and open areas on their bodies. They had to wash their hands before and after being in the residents' room and wear gowns, gloves, and sometimes a mask. If staff did not know what personal protective equipment was required, they looked at the sign and it told them what they needed. No one should go into an enteric precaution room without donning personal protective equipment. Resident #312 was on enteric precautions, and they had a sign and personal protective equipment bin outside their room. They were educated on transmission-based precautions on orientation and annually. 10 NYCRR 415.19(a)(b)