STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335548	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey conducted [DATE]-[DATE], the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care person-centered care plan, and the resident's choices for one (one) of three (3) residents (Resident #85) reviewed. Specifically, Resident #85 had an unwitnessed fall on [DATE] at 6:00 PM and there was no documented evidence the resident was assessed by a qualified professional. Findings include:The facility policy Falls Management and Prevention, revised 1/2023, documented in the event a resident had fallen and/or was found on the ground, a completed head-to-toes assessment must be performed. Resident #85 had diagnoses including chronic obstructive pulmonary disease (lung disease), high blood pressure, and anxiety disorder. The [DATE] admission Minimum Data Set assessment documented the resident was cognitively intact, required partial assistance of one for toileting hygiene, supervision for toilet transfers, and had falls in the last month prior to admission. The Comprehensive Care Plan initiated [DATE] documented the resident was at risk for falls/had actual falls related to history of falls. Interventions included provide toileting assistance per resident needs and therapy recommendations. The comprehensive care plan initiated [DATE] documented the resident required assistance with self-care and mobility related to mild femoral head osteophytes (limited range of motion due to bone irregularities at the hip). Interventions included toileting hygiene and toilet transfers with partial assistance of one person. The [DATE] at 6:00 PM Licensed Practical Nurse #21 progress note documented Resident #85's roommate informed them Resident #85 was on the floor, sitting next to their bed. Vital signs were taken and were stable, range of motion was within normal limits, and there were no signs of injury at the time. The supervisor and on call medical provider were called and no return calls were received. Physician Assistant #36 was notified. There was no documented evidence the resident was assessed by a qualified individual after being found on the floor in their room. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] Accident/Incident Folder included:-on [DATE] at 6:00 PM, Certified Nurse Aide #30 documented they were assigned to Resident #85's care. The resident was found on their knees in the bathroom. The resident thought they could toilet themself. Certified Nurse Aide #30 documented the resident was sitting in their wheelchair in their room at 5:30 PM, when they cleaned them, and they did not use their call light. -on [DATE] at 6:00 PM, Certified Nurse Aide #42 documented Resident #85's roommate came out and told them about Resident #85. Resident #85 was trying to use the toilet prior to their fall. They documented they thought the resident was becoming more unsteady.-on [DATE] at 6:00 PM, Licensed Practical Nurse #21 documented they heard about the incident (fall) from Resident #85's roommate. Licensed Practical Nurse #21 went into the resident's room, checked their safety, and took vitals. They documented the resident stated they went to the bathroom, then felt dizzy and sat on the floor. They notified the supervisor (unnamed) at 6:30 PM.-on [DATE] at 6:00 PM, Licensed Practical Nurse #9 documented they heard about the incident from the staff. Staff reported the resident was in the bathroom on the floor. The supervisor (unnamed) was notified at 6:52 PM by Licensed Practical Nurse #9. Resident #85 expired on [DATE] at 6:02 AM.During an interview on [DATE] at 11:35 AM, Certified Nurse Aide #30 stated the resident had a fall on [DATE] in the evening while attempting to use the bathroom on their own. They were found on the floor in the bathroom. Resident #85 had two falls on [DATE], once in the bathroom, and another next to the bed. The resident was assessed before being assisted off the floor using a mechanical lift. They could not recall who assessed the resident. They did not have a registered nurse in the building during the 2:00 PM –10:00 PM shift, so they had to call someone for a video call. During a telephone interview on [DATE] at 2:19 PM, Licensed Practical Nurse #21 stated they did not recall any falls for Resident #85. If a resident had a fall, they checked on them, checked to see if it was safe, and checked for injury. The supervisor needed to assess the resident. The registered nurse would do the assessment. If there was no registered nurse in the building, they should call the on-call registered nurse and inform them about the fall and they could video call for the assessment. They would notify the medical providers, and document in the resident's chart about the fall and who they spoke to. During a telephone interview on [DATE] at 12:26 PM, Assistant Director of Nursing #22 stated Resident #85 experienced a couple of falls but could not recall when. If they were notified of the fall, they would review the resident's vitals, call medical, and notify family. If medical was not in the building, they could do a video call to allow them to get a visual of the resident. They could ask the resident to move limbs, view their skin, observe for bleeding, ask the nurse on site to complete a neurological assessment, and check length of limbs to see if there was a difference. They never completed a video call for Resident #85. Resident #85 had a fall prior to expiring, but they were not part of the investigation or assessment.During an interview on [DATE] at 12:32 PM, the Director of Nursing stated the process to complete an assessment if there were no registered nurses in the building was to contact telehealth with the Medical Director Services. They should call the provider, and the provider could look at them and give orders. They should contact the registered nurse and let them know. They provided education for the staff to contact the Medical Provider first. If staff contacted the Medical Provider with telehealth there would be a telehealth note in the progress notes or uploaded.10NYCRR 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, observations, and interviews during the recertification and abbreviated (#2565048) surveys conducted 09/22/2025-11/20/2025, the facility did not ensure residents received adequate supervision to prevent accidents for two (2) of three (3) residents (Residents # 70 and #80) reviewed. Specifically, Resident #70's physician orders documented aspiration precautions (used to prevent food, fluids, or secretions from entering the airway) with no straws, the resident was provided a straw during meals and was not assisted with meals as care planned; Resident #80 did not have planned fall interventions in place and their call bell was not in reach. Findings include: The facility policy Aspiration Precautions, revised 12/2023, documented the resident would be offered food and liquids at a rate and portion size the resident was able to tolerate. The resident would be monitored for pocketing (holding food in mouth without swallowing) or coughing during and after intake of food and liquids. The facility policy Activities of Daily Living (ADL) Care and Support, revised 02/2025, documented activities of daily living care and support were provided for residents who were unable to carry out activities of daily living independently in accordance with the resident's assessed needs and individualized plan of care. 1) Resident #70 had diagnoses including dysphagia (difficulty swallowing), dementia, and acute respiratory failure with hypoxia (low oxygen). The 08/10/2025 Minimum Data Set assessment document the resident had severely impaired cognition, did not reject care, required supervision or touching assistance with eating, coughed or choked during meals or when swallowing medications, and received a mechanically altered diet. The Comprehensive Care Plan initiated 4/16/2020 and revised 5/12/2025, documented the resident required partial assistance with meals. The 05/09/2025-06/04/2025 Occupational Therapist #31 Discharge Summary documented the resident required minimum assistance at meals. The 08/04/2025 at 8:54 AM, Registered Nurse #24 progress note documented an interdisciplinary team referral for speech therapy due to the resident's difficulty following directions, food falling out of their mouth, and poor lip closure. The resident had noted difficulty with chewing and was coughing at times on thin liquids. The 08/04/2025 at 8:57 AM, Registered Nurse #24 progress note documented the resident had increased chewing at times and was coughing on liquids. The resident reported they were having more difficulty with certain items, their diet was downgraded, and a referral was placed for speech therapy. The 08/24/2025-08/30/2025, Speech Language Therapist #25 Speech Therapy Evaluation and Plan of Treatment documented the resident would be seen for skilled therapy to assess and determine least restrictive diet, reduce sign and symptoms of aspiration to enhance quality of life, and safely swallow without signs/symptoms of dysphagia. The 08/29/2025, physician order documented the resident was to receive a regular mechanical soft (ground) diet, nectar thick liquids, small bites and sips, and no straws related to dysphagia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 08/31/2025-09/13/2025, Speech Language Therapist #25 Progress Report completed documented the resident continued to receive mechanical soft solids and nectar thick liquids and continued to be seen for skilled interventions. The current care instructions documented the resident required partial assistance of one person at meals and received mechanical soft solids and nectar thick liquids. During an observation on 09/24/2025 at 1:17 PM, Resident #70 was sleeping in their bed and Certified Nurse Aide #30 placed the resident's lunch tray on the over the bed table and left the room. Speech Language Pathologist #25 was seated in the hallway outside of the room working with another resident. At 1:32 PM, the resident continued to sleep in bed without assistance while Certified Nurse Aide #30 sat in a chair in the hallway. At 2:11 PM, Resident #70's meal tray remained in front of them. They consumed 0-25% of their Health Shake, 100% nectar thick juice, and 0-25% of the chicken, beets, potatoes, and pudding. During an interview on 09/24/2025 at 1:47 PM, Certified Nurse Aide #30 stated they were assigned to Resident #70 today and their shift was over at 2:00 PM. If a resident was on aspiration precautions the resident should be seated up right. Staff did not have to sit with them during meals but should check on them to make sure they were not experiencing any swallowing issues. If a resident required partial assistance at meals staff should provide verbal cues and assistance if needed. Resident #70 was at risk for aspiration and received a ground diet with nectar thick liquids. The resident at times did not like to get out of bed and staff made sure the head of the bed was upright and checked on them while they ate. The resident did need assistance with meals and staff should encourage them to eat. They did not assist the resident at the lunch meal because they thought Speech Language Pathologist #25 was going to work with the resident. During an observation on 09/24/2025 at 2:11 PM, Resident #70's meal tray remained in front of them. They consumed 0-25% of their Health Shake, 100% nectar thick juice, and 0-25% of the chicken, beets, potatoes, and pudding. At 2:12 PM, Certified Nurse Aide #30 entered Resident # 70's room with their purse and asked the resident if they were going to eat, did not assist the resident, and exited the room at 2:13 PM. At 2:16 PM, Certified Nurse Aide #32 entered the resident's room and stood next to their bed. They provided the resident with a straw for their Health shake and left the room and entered another resident's room. At 2:20 PM, the resident remained in their room with their lunch meal and a straw in their Health Shake. During an interview on 09/24/2025 at 2:20 PM, Licensed Practical Nurse #9 stated Resident #70 was on aspiration precautions should not have straws and did not need assistance with meals. During an interview on 09/24/2025 at 2:27 PM, Licensed Practical Nurse #33 stated Resident #70 was on aspiration precautions and staff should assist the resident with their meals. They were not made aware the resident was not assisted at meals and did not provide any supervision at the lunch as they were busy with another resident. During an interview on 09/24/2025 at 2:32 PM, Certified Nurse Aide #32 stated they started their shift at 2:00 PM and noticed Resident #70 still had their lunch meal in front of them. They did not look at the resident's ticket and provided the resident with a straw so they could drink their Health Shake. They did not provide any additional meal assistance to the resident as they were rounding the unit at the start of their shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/24/2025 at 2:41 PM, Speech Language Pathologist #25 stated aspiration precautions could be implemented by nursing staff when a resident had issues with swallowing. Resident #70 was currently on their caseload as they were having issues with swallowing at meals. Their recommendations were no straws, alternating solids and liquids, and their diet order was currently mechanical soft solids and nectar. The resident was a high risk for aspiration and should not have straws with their liquids. They stated they had been working another resident at breakfast and noticed Resident #70 was not being assisted and assisted the resident. They did not tell nursing staff they were going to assist the resident at lunch today. During an interview on 9/24/2025 at 4:40 PM, The Regional Director of Therapy stated occupational therapy determined the level of assistance required at meals. Resident #70's discharge recommendations included partial assistance at meals. Partial assistance included sitting with the resident, assisting them as needed, providing verbal encouragement, and cues. During an interview on 10/1/2025 at 12:38 PM, The Assistant Director of Nursing stated if a resident was on aspiration precautions staff should visually monitor the resident during meals, and ensure they were seated upright. The certified nurse aides should check the resident's care instructions to ensure they were providing the correct assistance with meals. Staff should open cartons, remove lids, and cut food up if a resident required partial assistance. Resident #70 was on aspiration precautions and required partial assistance at meals. 2) Resident #80 had diagnoses including diabetic neuropathy (nerve damage), cataracts, and obesity. The 07/29/2025 Minimum Data Set documented the resident had moderately impaired cognition, was dependent for transfers and dressing, and did not have a history of falls. The 10/10/2023 Comprehensive Care Plan documented Resident #80 was at risk for falls and has had an actual fall related to deconditioning, gait/balance problems, immobility, incontinence, bilateral lower extremity and foot ulcers with resulting pain and discomfort, right Bundle branch block, and peripheral neuropathy. Interventions included to anticipate and meet the resident's needs, be sure their call light was in reach and encourage to use, bed in the lowest position, and floor mats at bedside as indicated. The 7/28/2025 Unit Manager Quarterly Evaluation documented a fall risk assessment. The resident was on antihypertensives and nonsteroidal anti-inflammatory drugs more than three times a week, had some issues with memory and recall, had adequate vision, was totally incontinent, was confined to a chair, and was unable to independently come to a stand. The intervention initiated to decrease fall risks was to wear non-skid socks. The resident was observed at the following times: -on 09/22/2025 at 7:53 AM in bed with two fall mats folded up on the wheelchair in the corner of their room. Their bed was raised to hip height and was not in the lowest position. -on 09/23/2025 at 3:05 PM in bed with the bed at hip height. The fall mats were in the wheelchair next to the wall. The resident needed assistance, and their call light was on the floor underneath the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 09/24/2025 at 11:40 AM in bed with the bed at thigh height. The call light was under the bed cross bar and not within reach. The resident stated that they did not get help when they needed it as they were supposed to use the call light, but they could not reach it. At 2:01 PM, the resident was in bed and there was one fall mat on the floor between the bed and window. The Acting Director of Nursing was in the room to check the resident's oxygen. At 2:04 PM, the resident's call light was under the bed not within reach. -on 09/25/2025 at 11:44 AM lying in bed with their call light under the cross bar under the bed. There was no fall mat on the side between the resident's bed and their roommate's bed. The second fall mat was folded behind the resident's wheelchair. Certified Nurse Aide #28 entered the resident's room to provide care. At 12:01 PM, Certified Nurse Aide #28 left the resident's room, and the call light was on the floor underneath the resident's bed. -on 09/29/2025 at 1:43 PM in bed with only one fall mat on the floor and the other folded up. Their resident's call light was on the floor out of reach. During an interview on 09/25/2025 at 9:06 AM, Registered Nurse #24 stated the care plan or the Kardex (care instructions) contained what fall interventions a resident needed. They stated Resident #80's care plan did not specifically state how many mats they were supposed to have at the bedside, but it did have mats as in plural. The fall mats should be in place if the resident was in bed. The resident's call light should always be in reach. During an interview on 09/25/2025 at 12:01 PM, Certified Nurse Aide #28 stated they knew what fall precautions needed to be in place for a resident by the resident's care plan. If a resident's care plan documented to have fall mats in place, they should be in place. Resident #80 was supposed to have two fall mats in place. The second fall mat was likely put up to provide the resident their tray and whoever picked up the tray did not replace it. It should have been replaced after the resident was finished with their meal. They stated the resident's call light was in reach, they had just picked it up and put it on the bed as well as putting the bed in the lowest position. 10 NYCRR 415.12(h)(1)(2)