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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the recertification survey conducted [DATE]-[DATE], the facility failed to provide cardiopulmonary resuscitation prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for one (1) of three (3) residents (Resident #85) reviewed. Specifically, Resident #85 had a physician order for cardiopulmonary resuscitation (chest compressions and rescue breathing when there is no pulse and/or respirations) and an advance directive for cardiopulmonary resuscitation to be attempted. On [DATE], Resident #85 was found without a pulse and was not breathing, and staff did not initiate cardiopulmonary resuscitation. The resident was pronounced deceased by Emergency Medical Services. The facility's failure to administer cardiopulmonary resuscitation resulted in Immediate Jeopardy and Substandard Quality of Care to Resident #85 and placed all 79 residents in the facility with Advance Directives at risk for serious harm, serious injury, serious impairment or death. Findings include:The facility policy Code Blue/Cardiopulmonary Resuscitation, dated [DATE], documented, in accordance with the resident's code status (e.g. full code), cardiopulmonary resuscitation would be initiated upon recognition of cardiopulmonary arrest (e.g., no pulse, no respirations, no audible blood pressure).Resident #85 had diagnoses including chronic obstructive pulmonary disease (lung disease), high blood pressure, and anxiety disorder. The [DATE] admission Minimum Data Set (a resident assessment tool), documented the resident was cognitively intact. Resident #85's baseline admission care plan did not include code status. The resident's Medical Orders for Life-Sustaining Treatment, signed by the resident on [DATE], documented the resident wished for cardiopulmonary resuscitation should they have no pulse and/or was not breathing. Physician #4's orders documented: -On [DATE], cardiopulmonary resuscitation order: attempt cardiopulmonary resuscitation.-On [DATE], please see Medical Orders for Life-Sustaining Treatment. The 07/2025 Medication Administration Record documented cardiopulmonary resuscitation order: attempt cardiopulmonary resuscitation, please see Medical Orders for Life-Sustaining Treatment. The [DATE] at 6:26 AM, Licensed Practical Nurse #7 progress note documented they entered Resident #85's room at 5:30 AM and found the resident unresponsive, cold to touch, rigid and no color, no signs of life, and no respirations or pulse. They immediately called the Director of Nursing and the on-call provider service. They last saw the resident alive and breathing around 3:20 AM when the certified nurse aide (not identified) asked for assistance to change the resident and the linen on the bed. The Assistant Nurse Manager arrived at the facility around 5:45 AM, taking charge of the situation. The Assistant Nurse Manager called 911 after arriving (no identified time) and notified the family. The on-call provider service had not called back as of 6:39 AM. The [DATE] at 6:30 AM Licensed Practical Nurse Assistant Unit Manager #6 progress note documented they were notified by the 10:00 PM - 6:00 AM nurse the resident was found with no pulse, and no response to stimuli. Emergency Medical Services and Physician #4 (previous Medical Director) were notified. Emergency Medical Services pronounced the resident deceased (no time documented). The [DATE] at 6:55 AM Licensed Practical Nurse #7 progress note documented the on-call physician returned their call at 6:50 AM. The [DATE] ambulance service Patient Care Record completed by (continued on next page)

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

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Paramedic #16 (third party ambulance service) documented they were called for an obvious death. Upon their arrival, the supervisor (facility) stated they just arrived and called 911. The resident was last seen between 3:00 AM and 3:30 AM, sitting on the edge of the bed. Paramedic #16 assessed Resident #85's vitals and noted their jaw was stiff, and all other extremities were movable. Resident #85 was pronounced dead at 6:02 AM. The [DATE] Licensed Practical Nurse #7 Charting by Exception note documented it was an addendum to the note on [DATE]. The writer was aware of the resident's code status being a Full Code. When the writer found the resident with no pulse, no respirations, no color, cold to the touch, rigid, signs of blood pooling, and dependent lividity they knew cardiopulmonary resuscitation was futile and did not begin it. They attempted to call the on-call provider multiple times with no return call. The Assistant Unit Manager arrived and attempted to call Physician #4 (previous Medical Director), was unable to contact them, and called 911. Emergency Medical Services arrived, did not initiate cardiopulmonary resuscitation and pronounced the time of death. The unsigned [DATE] facility Investigative Summary documented an unexpected death on [DATE].-on [DATE] at approximately 5:30 AM, Licensed Practical Nurse #7 entered Resident #85's room and found them unresponsive without a pulse or respirations. They checked the Medical Orders for Life-Sustaining Treatment and noted the resident wished to have cardiopulmonary resuscitation. They noted the resident was cold, rigid, signs of blood pooling, and signs of dependent lividity were present. The licensed practical nurse stated they felt cardiopulmonary resuscitation was futile. They called the provider and 911. Emergency medical technicians and police arrived at approximately 5:45 AM. A telephone call was placed to the Director of Nursing at approximately 5:42 AM. The emergency medical technicians pronounced the resident (deceased) at 6:02 AM.-The [DATE] at 5:53 AM statement from Certified Nurse Aide #5 documented while doing rounds (time not included) Resident #85's breathing was wet sounding, and the licensed practical nurse (unnamed) was in the room with them. The licensed practical nurse said they would let the right staff know. They left to care for other residents and Licensed Practical Nurse #7 called them back (time not documented) to the resident's room because the resident was cold and no longer breathing.-The [DATE] Licensed Practical Nurse #7 statement documented at around 5:30 AM they entered Resident #85's room and found the resident with no signs of life, no respirations, no pulse. They were last in the resident's room at 3:30 AM helping the certified nurse aide lift the resident into bed. The Director of Nursing was called immediately along with the on-call provider. No return call was received from the on-call provider.-The undated statement by Licensed Practical Nurse Assistant Unit Manager #6 documented they were notified Resident #85 was unresponsive and had passed at 5:40 AM as they were driving to the facility and was instructed to get to the room and assess. When they arrived (no time) the resident was lying in bed unresponsive, cold, pale, mouth open with their jaw to their chest, arms rigid, fluid filled forearms, and mottled lower extremities. They called 911. When Emergency Medical Services arrived, they pronounced the resident and the police took statements.-The [DATE] Certified Nurse Aide #5's clarification of their statement completed by telephone by Acting Director of Nursing #2 documented when they described the resident's breathing as wet, they meant it sounded like the resident was having trouble breathing. Licensed Practical Nurse #7 evaluated the resident and left to make a phone call.During an interview on [DATE] at 2:23 PM, Licensed Practical Nurse #7 stated they found Resident #85 unresponsive, rigid with blood pooling in their fingers, and was clearly deceased . They did not start cardiopulmonary resuscitation based on those observations. If they knew it was going to be a whole situation, they would have just done cardiopulmonary resuscitation and they would do it now. They stated when they found Resident #85, they called out for Certified Nurse Aide #5, then called Registered Nurse #17 (Director of Nursing at the time). There was no registered nurse in the building, but the Director of Nursing was on call. They were told to contact the on-call provider service. When the on-call provider did not call back, they contacted Registered Nurse #17 again. By that time, Licensed Practical Nurse Assistant Unit Manager #6 arrived and called 911. During a telephone interview on [DATE] at 11:46 AM, Certified Nurse Aide #5 stated they provided (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	care for Resident #85 on [DATE] at 3:20 AM. They left the resident and assisted a couple of other residents and used the rest room when Licensed Practical Nurse #7 found Resident #85 unresponsive. They stated they could not recall what time it was. When they walked in the resident's room to help Licensed Practical Nurse #7, the resident was limp. Licensed Practical Nurse #7 left the room and made some phone calls. Licensed Practical Nurse #6 then came in at about 5:45 AM. They were not sure what happened after that as they returned to certified nurse aide tasks, because they were the only certified nurse aide on the unit. During a telephone interview on [DATE] at 12:41 PM, Licensed Practical Nurse Assistant Unit Manager #6 stated Resident #85 passed over the summer and was a full code and did not have cardiopulmonary resuscitation performed. Resident #85 was passed for some time when they got to the facility at about 6:00 AM on [DATE]. The resident's skin was cold, and they appeared rigid. They called 911 at that time. Licensed Practical Nurse #7 told them they made the judgement call the resident was dead, and did not start cardiopulmonary resuscitation. They stated there was no registered nurse on the overnight shift. During a telephone interview on [DATE] at 5:00 PM, Registered Nurse #17 stated if the Medical Orders for Life Saving Treatment documented full code, cardiopulmonary resuscitation should be initiated and 911 called. Emergency Medical Services could make the decision to terminate the resuscitation efforts. There was a caveat, if the resident had signs and symptoms of rigor mortis there was a possibility not to do cardiopulmonary resuscitation. They were not sure if the decision to not initiate cardiopulmonary resuscitation due to rigor was an assessment or an observation. If it was an assessment then a registered nurse would make that decision, but if it was based on observations a licensed practical nurse could make that decision. The initiation of cardiopulmonary resuscitation should occur quickly after reviewing the Medical Orders for Life Saving Treatment. They were aware Resident #85 did not have cardiopulmonary resuscitation initiated when they were listed as a full code on the Medical Orders for Life Saving Treatment. They stated they received a phone call in the early morning on [DATE] from Licensed Practical Nurse #7 stating they found Resident #85 who was clearly deceased , was cold and rigid, and they did not start cardiopulmonary resuscitation, and did not know what to do. They advised Licensed Practical Nurse #7 to call 911 and the provider, because there was no registered nurse in the building. They did not instruct them to start cardiopulmonary resuscitation. They were not aware Licensed Practical Nurse #7 did not contact 911. During a telephone interview on [DATE] at 4:47 PM, Physician #4 stated when a resident wished to be a full code the expectation was to resuscitate them. If the resident was found unresponsive, without a pulse or respiration, staff should try to resuscitate. Cardiopulmonary resuscitation should be initiated right away. Licensed practical nurses should initiate cardiopulmonary resuscitation and contact Emergency Medical Services. They were aware Resident #85 was a full-code and cardiopulmonary resuscitation was not started. They were notified the next day when they were contacted to sign the resident's death certificate. During an interview on [DATE] at 5:13 PM, the Administrator stated if a resident was found without a pulse or respirations, a Code Blue should be called, and the Medical Orders for Life Sustaining Treatment should be checked for the code status. If a resident wished to be a full code, cardiopulmonary resuscitation should be given. In the case where rigor mortis was present, cardiopulmonary resuscitation would not be started. The determination to initiate cardiopulmonary resuscitation should be made by a registered nurse assessment. At the time of Resident #85's death, there was no registered nurse in the building. The Licensed Practical Nurse found the resident stiff and called 911 and did not start cardiopulmonary resuscitation as the body was stiff. The Licensed Practical Nurse tried to get in contact with medical and nursing. The facility followed the American Heart Association guideline, if a resident had rigor mortis, they would not start cardiopulmonary resuscitation. On [DATE], 911 was called and Emergency Medical Services determined Resident #85 had passed away. 10 NYCRR 415.3(e)(2)(iii)----------The Administrator was notified of the Immediate Jeopardy on [DATE] at 5:52 PM. The Immediate (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Jeopardy was removed on [DATE] prior to survey exit based on the following corrective actions taken:-On [DATE] the facility reviewed their Code Blue/ [Cardiopulmonary Resuscitation], policy and made no changes. - All staff identified for education received education by [DATE], except two staff who were not available. The two staff who did not receive education were to complete education upon their return, prior to the start of their shift.- Staff Interviews were completed on [DATE] and determined compliance with training and retention of educational content.- The Administrator was notified on [DATE] at 12:42 PM the Immediate Jeopardy was lifted.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the recertification survey conducted [DATE]-[DATE] the facility failed to promptly notify the ordering physician of laboratory results that fell outside of clinical reference ranges for 3 of 3 residents (Residents #41, #60 and #85) reviewed. Specifically:-Resident #85 had abnormal laboratory values on [DATE] and [DATE] that were not reviewed timely or assessed by the medical provider. -Resident #41 had a critical laboratory result on [DATE] with no documented provider notification until [DATE]. - Resident #60 had abnormal laboratory and a positive wound culture on [DATE]. The results were not reviewed until [DATE]. This resulted in the likelihood of serious injury, serious harm, or death that was Immediate Jeopardy to resident's health and safety for all residents with ordered laboratory tests.Findings include: The facility policy Lab/Test Results - Reporting, revised 9/2019, documented upon completion of the test, the lab would send written results to the facility, and communication would be via fax or electronic depending on the facility's capabilities. The nurse would call or fax the abnormal results to the physician. When the nurse called or faxed the results to the physician, the nurse would write a note with results reported, to who, and when.The electronic medical record Lab Results report documented a legend for flags included on the report. A red stop sign with an exclamation mark in the center indicated the report contained critical results (results in red text). A yellow triangle with an exclamation mark in the center indicated the report contained abnormal results (results with orange text). 1) Resident #85 had diagnoses including hypertension (high blood pressure) and chronic obstructive pulmonary disease (lung disease). The [DATE] Minimum Data Set assessment documented the resident was cognitively intact.A [DATE] physician order documented complete blood count with differential (a blood test that measures the number and size of different cells in the blood); basic metabolic panel (a blood test used to provide information about fluid balance, metabolism, and kidney function); and B-type natriuretic peptide (measures heart health) to be drawn on [DATE] for routine monitoring. The [DATE] Lab Results Report documented the results were reported [DATE] at 10:34 AM and included a yellow triangle with an exclamation mark in the center indicating the report contained abnormal results. The abnormal results included B-type natriuretic peptide (indicates heart health) 241 picograms/milliliter (reference range <125); sodium (electrolyte) 123 millimoles/liter (reference range 136-145); chloride (electrolyte) 91 millimoles/liter (reference range 98-107); blood urea nitrogen (indicates kidney function and/or fluid status) 28 milligrams/deciliter (reference range 9-23); blood urea nitrogen/creatinine ratio (provides information on kidney function) 25 (reference range 9-23); glucose (blood sugar) 156 milligrams/deciliter (reference range 70-99); red blood cells 3.65 total volume 30 microliters (reference range 4.60-6.10); hemoglobin (transports oxygen) 11.5 gram/deciliter (reference range 13.5-18.0); and hematocrit (percentage of red blood cells in total volume of blood) 34.1% (reference range 41.0-53.0). There was no signature indicating the results were reviewed when received. The report documented the labs were reviewed by Acting Director of Nursing #2 on [DATE] at 8:24 AM, over one month after receiving results. The [DATE] untimed Physician Assistant #36 progress note documented the resident was seen for an acute visit for chest congestion and pain following recent falls. There was no documented evidence the [DATE] lab results were reviewed. There were no documented nursing progress notes addressing the resident's abnormal labs on [DATE]. A [DATE] physician order documented basal metabolic panel for routine monitoring to be drawn on [DATE]. The [DATE] Lab Results Report documented the results were reported on [DATE] at 10:26 AM and included a yellow triangle with an exclamation mark in the center indicating the report contained abnormal results. The abnormal results included sodium 121 millimoles/liter (reference range 136-145); potassium (electrolyte) 5.8 millimoles/liter (reference range 3.5-5.1); chloride 90 millimoles/liter (reference range 98-107); blood urea nitrogen 42 milligrams/deciliter (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	surgical site draining purulent drainage, it was cultured and came back as methicillin resistant staphylococcus aureus. The stump incision looked more degraded. The assessment was the resident had methicillin resistant staphylococcus aureus positive culture, and the resident was to start Bactrim DS 1 tablet every 12 hours for 10 days. During a telephone interview on [DATE] at 10:24 AM, laboratory Customer Service Representative #12 stated abnormal labs were reported to the facility via automatic fax five times a day after resulting. Critical lab values were called to the facility, and a note was added to the lab results with the person the results were reported to. Resident #85 did not have results called to the facility because they did not meet the critical value criteria. During an interview on [DATE] at 1:18 PM, Registered Nurse Unit Manager #13 stated Resident #85 had labs drawn on [DATE] and included an abnormal B-type natriuretic peptide for the heart. The level was high at 241 and should be less than 125; the sodium was 123 and should be around 136-145, Glucose was 156, should be 70-99. The provider was responsible for reviewing the labs. They did not see any documentation the labs were reviewed. There was no documentation the provider was notified. They stated the expectation was once the abnormal value was identified; notification should be immediate. A progress note could be created from the lab screen when the provider was notified, and there were no notes about provider notification Resident #85's [DATE] laboratory results. During a telephone interview on [DATE] at 3:33 PM, Licensed Practical Nurse Assistant Unit Manager #6 stated they did not read the laboratory results for Resident #85. Licensed Practical Nurse #7 did. The Electronic Medical Record documented the labs were reviewed on [DATE], but it was their job to clear the dashboard (a screen in the electronic medical record showing pending labs in one view) in the morning. They reached out to former Director of Nursing #17 and Physician Assistant #36 came to the facility the following day. During an interview on [DATE] at 3:33 PM, Nurse Practitioner #11 stated they expected to be notified of abnormal laboratory results through the provider book, by fax, or by phone. They should be notified of abnormal or critical laboratory results to follow up with the resident and put in orders if needed. During an interview on [DATE] at 3:48 PM, Physician (Previous Medical Director) #4 stated they expected to be notified of abnormal labs, including on the weekends. They could be reached at any time, and if they were not available there was always an on-call provider available. They expected there to be documentation the provider was notified. The provider was responsible for the resident, no matter what the abnormal labs where they needed to be addressed. During a follow up interview on [DATE] at 9:32 AM, Nurse Practitioner #11 stated if an abnormal or critical lab resulted over the weekend, they expected staff to follow the policy and procedure to follow up on it. Resident #41's critical lab should have been communicated to them if they were in the facility when it came through. Resident #60 was started on antibiotics due to their wound culture results. They stated with Resident #41 they did not believe anything could have happened from not receiving the results earlier and they reached out to infectious disease to see if they needed to be on antibiotics. During an interview on [DATE] at 12:53 PM, Registered Nurse #13 stated all labs should be reviewed. The laboratory called the facility with critical reports and faxed abnormal results. The lab faxed results to two difference fax machines. The Minimum Data Set Nurse, the Director of Nursing, or they checked the fax machines. On the weekends, the electronic medical record dashboards were checked for laboratory results by nurses who would notify the on-call provider. They did not recall Resident #41's critical lab results for the creatinine. They believed the provider reviewed the laboratory result but was unaware it was not reviewed until the day after it resulted. Providers should be notified immediately of critical laboratory results, and the notification should be documented. A wound culture result received over a weekend should be reviewed as soon as possible. The licensed practical nurses should check their dashboard, and the providers should be notified as soon as possible. There was no standard way of informing a provider of laboratory results; sometimes the nurses called right away and sometimes they utilized the communication book. If they used the communication book, it was not reviewed until the next time the provider came into the facility. During an interview on [DATE] at 1:28 PM, the Acting Director of Nursing stated the facility (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	had a nurse practitioner and two physicians who oversaw the clinical side and when they were not there, there was an on-call service for medical needs. The nursing staff was responsible for letting the providers know when laboratory results were received, and the providers were responsible for reviewing the laboratory results. Critical laboratory results should be reported immediately to the providers. During an interview on [DATE] at 4:18 PM, the Administrator stated the lab identified critical values, and nursing staff should call the results to the provider immediately. Abnormal results were not the same level as critical but should still be reported to the provider as quickly as possible. Any nurse was able to call the on-call provider. They knew who to contact after hours and to contact the in-house provider during business hours. They stated notifying the provider two or three days later for an abnormal lab was too long to wait. Labs should be reported within 24 hours. During a telephone interview on [DATE] at 9:34 AM, Physician #14 stated labs should be reviewed by Nurse Practitioner #11 the day the results were available. Nurse Practitioner #11 should review labs daily and contact them with questions. They were not sure how critical labs were reported, but someone was usually called for critical labs. They were unaware of what arrangement Nurse Practitioner #11 had made with facility and if nursing called Nurse Practitioner #11 or the on-call service with laboratory results during off peak hours. Laboratory results should be reviewed the day they resulted and if it was a weekend, the nurse on-site should notify the on-call provider. Resident #41's critically high creatinine should have been addressed with at least a note by Nurse Practitioner #11 even if nothing was clinically done. A wound culture should be reviewed and the facility notified of the results timely. If a wound culture resulted on the weekend, the provider should be notified of the results. Resident #60's results should have been reported to Nurse Practitioner #11 or to the on-call the first day the results came back, and the results should have been addressed earlier. The providers should be notified of critical or abnormal laboratory results because it may not be appropriate to wait on those results and wait for the resident to be seen. A resident who had a potassium of 5.8 and a sodium of 121 could have seizures or go into a coma. The results would need to be addressed right away. During a telephone interview on [DATE] at 2:34 PM, Physician #3 stated laboratory results should be reviewed daily, particularly abnormal results. If the facility was not able to contact Nurse Practitioner #11 during the day, the facility should call them or Physician #14. Abnormal laboratory results over the weekend or afterhours should be reviewed by nursing staff and reported to the on-call service. Two days was too long for a wound culture to be reviewed, the wound culture should have been reported the day it came in. Three days was too long for an abnormal laboratory result to not be reviewed. A resident who had a high potassium of 5.8 and a low sodium of 121 could have altered mental status and there could be metabolic changes. It needed to be taken seriously. Those laboratory results were something they would hospitalize a resident over. It was important critical and abnormal laboratory results were reported to the providers so they could make the right clinical decisions for the patient such as ordering follow up labs or sending the resident to the hospital. 10 NYCRR 415.20 The facility has taken the following steps to lift the IJ in F773, issued [DATE] at 5:22 PM: The facility educated staff on reviewing labs in the dashboard and reporting requirements. Facility policy for lab reporting was reviewed without changes needed. Plan for immediacy was accepted on [DATE] at 6:53 PM. Complete IJ plan approved by team to start education on [DATE] at 12:30 PM. 100% of working staff have received stand up education as of [DATE] at 1:43 PM, with plans for ongoing education of staff prior to the start of their next shift for those not currently on the schedule. 92.3% of staff were educated based on education outline as of [DATE] at 3:34 PM. 96% of staff were educated based on the education outline as of [DATE] at 7:59 AM. Post tests reviewed; no discrepancies found in grading. Staff education sign in sheets were reviewed and compared to the current nursing staff list. 21 of 22 nursing staff and 4 of 4 medical providers were educated. Staff education was verified during an onsite visit(s) [DATE], multiple staff licensed nurses and providers were interviewed, no discrepancies identified. Staff were able to report content of education and the facility staff who presented the education. Lab dashboard reviewed on [DATE] at 9:45 AM and no labs awaiting review. Administrator was notified on [DATE] at 11:21 AM. Officially IJ lifted [DATE].

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide care by qualified persons according to each resident's written plan of care. Based on record review and interviews during the recertification and extended survey conducted 09/22/2025-11/20/2025, the facility did not ensure the services provided or arranged by the facility were delivered by individuals who had skills to do a particular task in accordance with each resident's written plan of care for 38 resident's with orders for cardio-pulmonary resuscitation (perform chest compressions in the absence of a heartbeat). Specifically, staff with current cardio-pulmonary resuscitation certification that met accepted national standards were not present in the building twenty-four hours per day. Findings include:The 03/13/2025 Facility Assessment Portfolio documented the services and care offered based on Resident Needs, and did not include Basic Life Saving skills or individuals requiring Cardiopulmonary Resuscitation certification.The facility job description for Licensed Practical Nurse, Registered Nurse Supervisor, Registered Nurse, and Unit Manager documented they must maintain and provide the facility with current license/certification as required by the position. Cardio-pulmonary resuscitation certification or Basic Life Saving skills were not listed within the job requirements. The revised 01/23/2015 Centers for Medicare and Medicaid Services, Memo #14-01-NH, Cardio-pulmonary Resuscitation in Nursing Homes, documented cardio-pulmonary resuscitation certified staff must be available at all times. Staff must maintain current cardio-pulmonary resuscitation certification for healthcare providers through cardio-pulmonary resuscitation training that includes hands-on practice and in-person skills assessment. Online-only certification was not acceptable. There was no documented evidence Licensed Practical Nurse #7, Licensed Practical Nurse Supervisor #26, and Licensed Practical Nurse #38 had cardio-pulmonary resuscitation certification. Licensed Practical Nurse #27 had a Cardiopulmonary Resuscitation certification from National Cardio-pulmonary Foundation issued on 7/24/2025. The National Cardio-pulmonary Foundation documented at the bottom of their training website, online training was a legal and acceptable form of training, however, in-person training was not offered. Employers or licensing boards may require in-person training for special industries. They could not guarantee the certification would be accepted in every situation. Licensed Practical Nurse #19 had a cardiopulmonary resuscitation certification from the American Health Care Academy issued on 7/23/2025. The American Health Care Academy website documented cardio-pulmonary resuscitation certification was offered online. The 07/10/2025-07/24/2025 nursing schedule documented the following nurses were the only nurses on shift:-Licensed Practical Nurse Supervisor #26 worked 6:00 PM to 6:00 AM on 07/14/2025, and Licensed Practical Nurse #27 worked 10:00 PM to 6:00 AM on 07/14/2025.-Licensed Practical Nurse #27 and Licensed Practical Nurse #38 worked 10:00 PM to 6:00 AM on 07/15/2025.-Licensed Practical Nurse Supervisor #26 worked 6:00 PM to 6:00 AM on 07/17/2025, and Licensed Practical Nurse #27 worked 10:00 PM to 6:00 AM on 07/17/2025.-Licensed Practical Nurse #7 and Licensed Practical Nurse #38 worked 10:00 PM to 6:00 AM on 07/20/2025.-Licensed Practical Nurse #7 worked 10:00 PM to 6:00 AM on 07/22/2025.-Licensed Practical Nurse Supervisor #26 worked 10:00 PM to 6:00 AM on 07/24/2025. The 09/21/2025-09/23/2025 Nursing Schedule documented the following nurses were the only nurses on shift:-Licensed Practical Nurse Supervisor #26 worked 10:00 PM to 6:00 AM on 09/22/2025.-Licensed Practical Nurse #27 worked 6:00 PM to 6:00 AM on 09/23/2025.-Licensed Practical Nurse #19 worked 7:30 PM to 6:00 AM on 09/24/2025. During an interview on 09/24/2025 at 5:30 PM, the Administrator and Corporate Director of Clinical Transformation stated they had to review the cardio-pulmonary resuscitation certifications they had for staff, as they did not know the National Cardio-pulmonary Resuscitation Foundation certifications did not include a hands-on skill evaluation. During a telephone interview on 09/24/2025 at 6:22 PM, American Health Care Academy's Customer Service was contacted with the Administrator present. The certification number for Licensed Practical Nurse #19 was provided. The customer service representative stated Licensed Practical Nurse #19 only purchased and completed the online course, and did not purchase or complete the hands-on skills (continued on next page)

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

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	portion. During an interview on 10/01/2025 at 12:38 PM, the Assistant Director of Nursing stated their role included providing nursing education and was responsible for documenting education that was provided. During an interview on 11/20/2025 at 12:32 PM, the Director of Nursing stated they were concerns about staff training prior to survey. They started at the facility in August 2025 and was not sure when the concerns about training was identified. They were not sure how much education was accomplished, but they identified training needed to be done. They did not know the process for licensed staff to complete their cardio-pulmonary resuscitation certification. They stated the normal process anywhere was people would go someplace to do the training in person, or it was provided in the facility. The interdisciplinary team had input into the Facility Assessment, the Administrator was responsible for ensuring the form was completed. The Facility Assessment was supposed to outline the education programs based on the needs of the facility. During an interview on 11/20/2025 at 1:32 PM, the Administrator stated the Assistant Director who was in charge of staff education, oversaw the completion of cardio-pulmonary resuscitation certification. Prior to the survey, they did not know who tracked cardio-pulmonary resuscitation certifications. They had previous Assistant Director of Nurses who did competencies, but they were unable to locate those specific binders. They were supposed to track the hands-on competencies for cardio-pulmonary resuscitation certifications. Cardio-pulmonary resuscitation certified individuals were required to meet the needs of the residents in the facility. 10 NYCRR 415.11(c)(3)(ii)

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	335548	A. Building B. Wing	11/20/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews during the recertification survey conducted 09/22/2025-11/20/2025 the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for one (1) of one (1) main kitchen and one (1) of one (1) dining room. Specifically, in the main kitchen prepared foods were not cooled properly, multiple boxes of food items were stored on the floor, food items were not dated, and areas of the kitchen were unclean; and the dining room had unclean and sticky floors, and multiple trays from the previous meal were stacked on a rolling rack.Findings included: The facility policy Rapid Cooling of Food, revised 01/2023, documented time/ temperature control for safety, food should be cooled rapidly. Time/ Temperature control for safety, food would be maintained at 135 degrees Fahrenheit or cooled to 40 degrees Fahrenheit. Food would be cooled from 135 degrees Fahrenheit to 70 degrees Fahrenheit within two hours. The procedure documented multiple steps to ensure proper cooling.The facility policy Food Storage, revised 05/10/2024, documented food items would be stored on shelves and off the floor. Food would be stored a minimum of six inches above the floor, 18 inches from the ceiling and two inches from the wall on clean racks or other clean surfaces, and would be protected from splashes, overhead pipes, or other contamination. Leftover food would be stored in covered containers or wrapped carefully and securely. Each item would be clearly labeled and dated before being refrigerated. Leftover food would be used within 24-72 hours. Meat, fish, and poultry would be stored on lower shelves, while fruits, vegetables, juices and breads should be stored on upper shelves.The undated facility policy Dining Room Cleaning Procedure, documented collect and remove all dirty dishes, utensils, and trays to the dishwashing area. Dispose of leftover food and trash into designated receptacles. Sweep or vacuum floors to remove crumbs and debris under tables, chairs, and edges. Spot mop spills immediately with disinfectant. After sweeping, damp mop the entire floor with a clean mop head and fresh solution.Dining Room:During an observation on 09/22/2025 at 6:32 AM, the main dining room had several meal trays on a rolling rack from the previous dinner meal. The floor was unclean and sticky. The surveyor's foot stuck to the floor as they walked through the dining room.Food Storage:During an observation in the main kitchen on 09/22/2025 at 6:34 AM, there were several boxes of food on the floor, including one box of crackers, two boxes of canned soup, and other various dry goods. At 6:42 AM, in the main walk-in cooler there was one metal pan of corn dated 9/17, one pan of sliced pineapple dated 9/18, and several proportioned 2-ounce plastic souffle cups unlabeled or dated. There were several undated sandwiches in a preparation cooler and unlabeled or dated 2-ounce plastic souffle cups.During an observation in the main kitchen on 09/24/2025 at 12:30 PM, there was one carton of raw eggs stored on a shelf above a bin of sliced apples, a bowl of pudding, and a container of butter chips (pickles) in the walk-in cooler.Kitchen Cleanliness:During an observation in the main kitchen on 09/22/2025 at 6:38 AM, the meat slicer was unclean with dried food debris. The hand washing sink had dried paper towels and a Band-Aid in the basin. At 7:00 AM, the dish room have several unclean dishes stacked up and the three- bay pot and pan sink had numerous stacked up unclean pots and pans.During an interview on 09/22/2025 at7:00 AM, the Food Service Director stated the dish room was a mess, as a staff member went home sick the previous evening.During an observation in the main kitchen on 09/24/2025 at 11:16 AM, the walk-in cooler shelving had areas of rust and were not smooth or easily cleanable.Improper Cooling:During an observation in the main kitchen on 09/24/2025 at 11:16 AM, the walk-in cooler had one container of vegetable soup dated 9/23. The vegetable soup measured 44 degrees Fahrenheit. When the temperature of the vegetable soup was rechecked at 11:38 AM, it remained unchanged at 44 degrees Fahrenheit.There was no documented evidence of completed food cooling logs.During an interview on 09/24/025 at 11:38 AM the Food Service Director stated the vegetable soup was from the previous dinner meal, they cooled the soup in a shallow pan and transferred it into a 3-gallon container. The (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	soup remained in the walk-in cooler since then. They could not recall the food cooling process, and they did not measure the temperature of the soup at any time. If the soup was not cooled properly, it should be discarded.During a follow up interview on 09/24/2025 at 3:28 PM, the Food Service Director stated the facility had not received any food deliveries on Monday 09/22/2025 prior to 6:00 AM. Food products should not be stored directly on the floor, and dishes, including pots and pans should be washed after every meal. All items in the walk-in cooler and prep coolers should be labeled and dated after opening and when transferred into other containers. The meat slicer should be cleaned after each use and the surfaces in the kitchen should be smooth and cleanable. They did not see the rust on the shelves in the walk-in cooler. Raw food items should not be placed above ready to eat food items in the cooler due to the potential of cross contamination. All food items should be stored properly, cooled properly, and kitchen areas should be clean to prevent food borne illness.During an interview on 10/01/2025 at 12:52 PM, the Director of Housekeeping and Laundry Services stated housekeeping staff should clean the dining room after each meal. This included wiping down the tables, removing trash, and mopping the floor. If the dining room floor was unclean and sticky it would not be considered homelike.During an interview on 10/01/2025 at 1:19 PM Housekeeper/Laundry Service Aide #40, stated their job included completing housekeeping duties and the resident's laundry. They cleaned the dining room at the end of their shift, they only partially mopped the dining room and would spot mop as needed. They did not have a lot of time to dedicate to the dining room and did not mop the dining room floor on the evening of 09/21/2025.During a follow up interview on 10/01/2025 at 1:27 PM the Food Service Director stated on the evening of 09/21/2025 there were two food service aides, and they were the cook/supervisor that evening. It was the responsibility of the food service staff to remove the trays from the dining room. It was not homelike to have dirty dishes from the previous meal in the dining room while the residents were eating their meal. 10NYCRR 483.60(i)(1)-(2)

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

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observations, record review, and interviews during the recertification and extended survey conducted 09/22/2025 - 11/20/2025, the facility failed to ensure its operations were administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, administration's actions, inactions, or decisions contributed to deficient practices rising to Immediate Jeopardy in F678, Cardiopulmonary Resuscitation and F773, Laboratory Notifications. Additionally, administration failed to ensure nursing staff had appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (F726, Competent Nursing Staff). Findings include: The undated facility Quality Assurance and Performance Improvement Plan documented the Quality Assurance and Performance Improvement committee was comprised of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Facility Educator, Unit Managers, Wound Nurse, nursing and ancillary staff and all department heads. The Quality Assurance and Performance Improvement Committee would oversee implementation of the Quality Assurance and Performance Improvement Plan. The objectives of the Quality Assurance and Performance Improvement plan included:-Provide a means to identify and resolve present and potential negative outcomes related to resident care and services.-Reinforce and build upon effective systems and processes related to the delivery of quality care and services.-Provide structure and processes to correct identified quality and/or safety deficiencies.-Establish and implement plans to correct deficiencies and to monitor the effects of these plans on resident outcome.-Help departments, consultant, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability.-Provide a means to centralize and coordinate comprehensive [Quality Assurance and Performance Improvement] activities in order to meet the needs of the residents and the facility; and-Establish systems and processes to maintain documentation related to the [Quality Assurance and Performance Improvement] Program, as a basis for demonstrating that there was an effective ongoing program.The undated job description for the Administrator of Record documented the primary purpose of the position was to direct the day-to-day functions of the facility in accordance with current Federal, State, and Local standards, guidelines, and regulations that governed skilled nursing facilities and nursing homes to assure the highest degree of quality of care was being always provided to the residents at the facility. The Administrator was responsible to direct all the facility employees in their specific roles and to ensure that each department was functioning efficiently and in accordance with all corporate policies and procedures. Essential functions included: ensure the proper function of the nursing department and the clinical staff; hire and direct a qualified and capable Director of Nursing; ensure all residents right to fair and equitable treatment, self-determination, individuality, privacy, confidentiality of information, property and civil rights including the right to lodge a complaint, were strictly enforced; and ensure all Department of Health reportable events were reported timely to the correct state or federal agency per state and federal regulations. The undated job description for the Director of Nursing documented they assumed authority, responsibility, and accountability for the delivery of nursing services in the facility. In collaboration with Administration, they allocated department resources in an efficient and economic manner to enable each resident to attain or maintain the highest practicable physical, mental and psycho-social well-being. The Director of Nursing was responsible for oversight, planning, organizing, developing, training and 24-hour management of the clinical nursing department in the Nursing Home and Rehabilitation Center and assisted with the planning, organization, development, coordination, and direction of the nursing department in its program and activities in accordance with current Federal, State, and local guidelines and regulations, accepted standards of practice. The Director of Nursing oversees and (continued on next page)

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

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	supervises development and delivery of in-service education to equip nursing staff with sufficient knowledge and skills to provide compassion, quality care, and respect for the resident rights. The 03/13/2025 Facility Assessment documented the average daily census was 75 residents. The list of current resident diagnoses included: psychiatric/mood disorders with common diagnoses of psychosis (hallucination and delusions), mental disorders, depression, bipolar disorder (mania/depression) schizophrenia, post-traumatic stress disorder, anxiety disorder, skin ulcers, urinary tract infections, infections with multi-drug-resistant organisms, diabetes, risk for bleeding or blood clots, and renal failure. The services provided by the facility were physical therapy, occupational therapy, speech therapy, medication administration, tube feeding, end of life care, and wound care (surgical, other skin wounds). Cardiopulmonary Resuscitation: Refer to the citation text under F678.On 07/22/2025, Resident #85 was found without a pulse and without respirations, and staff did not initiate cardiopulmonary resuscitation per the resident's wishes documented on their Medical Orders for Life Sustaining Treatment.This resulted in actual harm that was Immediate Jeopardy and Substandard Quality of Care to residents' health and safety.Lab Services/Physician Order/Notification of Laboratory Results: Refer to the citation text under F773.Residents #85, #60, and #41 had laboratory results that fell outside of the clinical reference range, and the ordering physician was not promptly notified of the results. This resulted in the likelihood of serious injury, serious harm, or death that was Immediate Jeopardy to residents' health and safety. Competent Nurse Staff: Refer to the citation text under F726.Licensed Practical Nurses #6, #7, #10, #27, and #29 did not have documented education or competencies completed annually in accordance with the needs identified in the Facility Assessment. Additionally, Licensed Practical Nurse #29 did not provide care to a resident with a feeding tube that met the professional standards.During an interview on 10/01/2025 at 12:38 PM, the Assistant Director of Nursing stated they were in their current role for just over two (2) months and were originally hired as a supervisor. They were part of the Administration team and were in contact with the Administrator and the Director of Nursing often. Their duties included the infection control program, education of facility staff, and anything related to nursing. They had been to some Quality Assurance and Performance Improvement committee meetings since starting in their role. Education was completed through a printed PowerPoint for different topics with posttests. Attendance was recorded by printed sign in sheets. Competencies were done through group discussions and posttests. They could not say if there had been any hands-on competencies completed. During an interview on 11/20/2025 at 12:32 PM, the Director of Nursing stated they were part of the administrative team and were part of the Quality Assurance and Performance Improvement committee. Once a concern was identified, it was discussed with the interdisciplinary team to determine if it needed a performance improvement plan. There were concerns noted with staff training prior to survey, but they could not state what or when it was identified. Education was part of the Assistant Director of Nursing's duties. There were no concerns identified regarding competency for nursing staff prior to the survey start. The registered nurses were very competent even if they did not have formal competencies documented. They were unsure what was occurring to ensure competencies were being completed upon hire and annually for staff prior to their start date. The performance improvement plan dated 09/05/2025 for the concerns identified regarding a lack of staff education was recently implemented with a skills fair in October 2025. They were unsure of what the process was for ensuring licensed staff had their cardiopulmonary resuscitation certification prior to survey entrance. The facility assessment was an interdisciplinary document the Administrator ensured was completed. The education program was supposed to outline the needs of the facility based on the facility assessment. During an interview on 11/20/2025 at 1:32 PM, the Administrator stated they had support through the nursing administration which included the Director of Nursing, unit managers, and nursing supervisors. The Assistant Director of Nursing was responsible for overseeing the completion of the cardiopulmonary resuscitation certifications with a hands-on component for the licensed staff as they oversaw education. They did not know how the (continued on next page)

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
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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility was tracking cardiopulmonary resuscitation certifications prior to survey entrance. Licensed staff who had their cardiopulmonary resuscitation certifications were required to meet the needs of the residents in the facility. Licensed staff were supposed to have competencies associated with the Center for Medicaid and Medicare Services regulations throughout the year. The Assistant Director of Nursing was also responsible for tracking the competencies of the staff and they were unsure how they were previously tracked. They stated they were responsible for completing the facility assessment. The education programs outline should meet the needs of the facility based on that assessment. 10 NYCRR 415.26(a)

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	335548	A. Building B. Wing	11/20/2025

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interviews during the recertification survey conducted 09/22/2025-11/20/2025, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for two (2) of three (3) residents (Residents #94 and #95) reviewed. Specifically, Residents #94 and #95 were discharged to home after discontinuation of Medicare Part A services and the facility did not provide the resident with the Notice of Medicare Non-Coverage (Centers for Medicare and Medicaid Services-10123) for Medicare Part A as required. Findings include:The Center for Medicare and Medicaid Services form Center for Medicare and Medicaid Services-10123 instructions documented a Medicare health provider must give an advance, completed copy of the Notice of Medicare Non-Coverage to enrollees receiving skilled nursing services, no later than two days before the termination of services. The Skilled Nursing Facility Beneficiary Protection Notification Review completed by the facility documented Resident #94 had a Medicare covered stay with a start date of 04/29/2025, and the last covered day of Part A services was 05/22/2025. The discharge was a facility-initiated discharge when benefit days were not exhausted.There was no documented evidence the Notice of Medicare Non-Coverage for Centers for Medicare and Medicaid Services-10123 letter was provided to Resident #94.Resident #95's 04/07/2025 discharge Minimum Data Set assessment documented the resident had a Medicare covered stay with a start date of 02/11/2025 and an end date of 04/07/2025. The discharge was a planned discharge with return not anticipated. There was no documented evidence the Notice of Medicare Non-Coverage for Centers for Medicare and Medicaid Services-10123 letter was provided to Resident #95.During an interview on 09/23/2025 at 3:05 PM, the Director of Rehabilitation #43 stated the Business Office Manager was responsible for issuing the Notice of Medicare Non-Coverage. They stated in the absence of the Business Office Manager and the Minimum Data Set Coordinator; they were the third person responsible for the issuing the Notice of Medicare Non-Coverage. The Notice of Medicare Non-Coverage was issued to inform residents their Medicare benefit covered services was ending. Resident #94's last coverage day was 05/22/2025 and they should have received a Notice of Medicare Non-Coverage at least two days prior. Resident #95's last covered days were 04/06/2025, they should have been issued a Notice of Medicare Non-Coverage on 04/04/2025. They were unable to locate the forms for Residents #94 and #95 in the computer system or determine if they were issues. They stated without the Notice of Medicare Non-Coverage being provided the resident would not know their services would be ending. During an interview on 09/23/2025 at 3:28 PM, Minimum Data Set Coordinator #44 stated Resident #95's Notice of Medicare Non-Coverage should have been issued by 04/04/2025 and Resident #94's Notice of Medicare Non-Coverage should have been issued on 05/20/2025, but there was no documentation they were issued. If the Notice of Medicare Non-Coverage was not provided to the resident, the facility could be liable for payment of services received by the resident. The resident could think they were eligible for services, if they remained in the facility. During an interview on 09/23/2025 at 3:50 PM, the Administrator stated the Business Office Manager was responsible for issuing the Notice of Medicare Non-Coverage. The Business Office Manager left their position at the facility in June 2025. There were gaps in the beneficiary notification process. The Administrator stated it became apparent during the survey process documentation for resident notifications were not being maintained how they should be. The Notice of Medicare Non-Coverage for Resident #95 should have been in their file, but they were not able to locate the files to confirm Resident #95 was notified as required. If the residents were not notified of non-coverage, benefits provided under Medicare would no longer be available to the resident, and the resident would not be advised of the appeal process. The residents could lose their right to appeal, and the resident could potentially be financially responsible for any Medicare non-covered services they received. 10 NYCRR 415.3(g)(2)(iii)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the recertification survey conducted [DATE] -[DATE], the facility did not ensure all investigations were reported to the State Survey Agency within five (5) working days of the incident for one (1) of three (3) residents (Resident #85) reviewed. Specifically, cardiopulmonary resuscitation was not initiated for Resident #85 per their Medical Orders for Life Sustaining Treatment and was not reported to the New York State Department of Health as required. Refer to F678 (Cardiopulmonary Resuscitation).Findings include: The facility policy Accident-Incidents, dated [DATE], documented the Director of Nursing and Administrator were responsible to review Incident/Investigations and conclusions to determine if incident required reporting to outside agencies such as the Department of Health.The 08/2016 New York State Department of Health Nursing Home Incident Reporting Manual documented at least one of the following elements must be present for an incident to be reportable to the [New York State Department of Health]:- Cardiopulmonary Resuscitation was not provided when it was required.- Cardiopulmonary Resuscitation was provider against a resident's wishes.- Cardiopulmonary Resuscitation was initiated and stopped when staff became aware of the resident wishes. Resident #85 had diagnoses including chronic obstructive pulmonary disease (lung disease) and high blood pressure. The [DATE] Minimum Data Set assessment documented the resident was cognitively intact. Resident #85's Medical Orders for Life-Sustaining Treatment, signed by the resident on [DATE], documented they requested cardio-pulmonary resuscitation be attempted when they had no pulse and/or was not breathing. The [DATE] physician order documented attempt cardio-pulmonary resuscitation. Resident #85's Comprehensive Care Plan did not include their wishes or orders for resuscitation. The unsigned [DATE] facility Investigative Summary documented an unexpected death on [DATE]. -on [DATE] at approximately 5:30 AM, Licensed Practical Nurse #7 entered Resident #85's room and found them unresponsive without a pulse or respirations. They checked the Medical Orders for Life-Sustaining Treatment and noted the resident wished to have cardiopulmonary resuscitation. The resident was cold, rigid, signs of blood pooling, and signs of dependent lividity were present. Licensed Practical Nurse #7 stated they felt cardiopulmonary resuscitation was futile. They call the provider and 9-1-1. Emergency Medical Technicians and police arrived at approximately 5:45 AM. A telephone call was placed to the Director of Nursing at approximately 5:42 AM. The Emergency Medical Technicians pronounced the resident deceased at 6:02 AM.-Review of the investigation was completed and there was no evidence to support any alleged resident abuse, neglect, exploitation, or mistreatment occurred. The incident was not reportable to the Department of Health. During a telephone interview on [DATE] at 5:00 PM, Registered Nurse #17 (former Director of Nursing in 07/2025) stated they were part of the investigation for the incident around Resident #85's death. The incident was not reported to the Department of Health, because they were told not to report. They were told it was not the Director of Nursing's decision to report incidents. They were advised by the Administrator not to report the incident. There were conversations with corporate staff who did not want it reported. They stated they knew it should have been reported. During an interview on [DATE] at 5:13 PM, the Administrator stated they did not report the death because they followed the American Heart Association guidelines, and it was not reportable. The incident information and investigation were gathered by Registered Nurse #17 (Former Director of Nursing). The Director of Nursing and they were responsible for reporting incidents to the New York State Department of Health. 10 NYCRR 415.4

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	335548	A. Building B. Wing	11/20/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews 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. 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 (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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	335548	A. Building B. Wing	11/20/2025

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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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	335548	A. Building B. Wing	11/20/2025

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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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	335548	A. Building B. Wing	11/20/2025

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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. -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 (continued on next page)

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	335548	A. Building B. Wing	11/20/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interview during the extended recertification survey conducted 09/22/2025-11/20/2025, the facility failed to ensure that licensed nurses had the appropriate competencies and skill sets necessary to provide nursing care and related services to assure residents safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident for five (5) of five (5) licensed nurses (Licensed Practical Nurses #6, #7, #10, #27, and #29) reviewed. Specifically, Licensed Practical Nurse #29 performed feeding tube care for Resident #5 that did not meet professional standards for infection control; and Licensed Practical Nurses #6, #7, #10, #27, and #29 did not have documented education or competencies completed annually in accordance with the needs identified in the Facility Assessment. Deficiencies were identified in the areas of Cardiopulmonary Resuscitation (F678) and Infection Control (F880). Findings include:The undated Facility Educator job description documented the Facility Educator was responsible for planning, organizing, developing, implementing, facilitating and evaluating all employees' education programs throughout the facility or campus, in accordance with the Company's policies and procedures current applicable federal, state, local standards, guidelines, and regulations to assure the highest degree of quality resident care could be maintained at all times. Essential functions included working in collaboration with all facility department directors in the orientation and education of staff to ensure mandatory and regulatory education requirements are met within the facility; conducted competencies in areas of nursing practice with attention to management of the medically complex patient; and regularly conducted education needs assessment for the facility to assist in identifying areas for improvement. They prepared, scheduled, and selected material, equipment, and training aides; scheduled and communicated in-services training programs according to the need of the facility; conducted regular scheduled meeting and education to all staff within the facility; facilitated training related to required certifications, and cardio-pulmonary resuscitation; and maintained attendance and documentation of in-services in accordance with regulatory guidelines and corporate policies. Monthly duties included but were not limited to: developing and posting monthly in-service calendars; developing a report for each department that addressed the evaluation of each employee's compliance to education requirements and evaluation status of each employees compliance to employee health regulations; met with each department director to discuss their department education needs; facilitated or conducted cardio-pulmonary resuscitation classes; and oversaw and provided orientation of new employees.The 3/13/2025 Facility Assessment Portfolio documented upon hiring all facility personnel would participate in general orientation and job specific orientation. The primary objectives of the facility staff training program were to provide the employees with an in-depth review of the established operation policies and procedures and evidence-based practices that would assist the employees in providing high quality care. Each facility department had job specific orientation with pertinent training topics and policy/procedures for that discipline, with the job specific curriculum and job specific competency. Ongoing monthly education curriculum would be determined based on facility needs, identified concerns, observed staff practices, regulatory requirements, or findings. All facility employees would receive mandatory education of the topics listed in the discipline chart. Nursing (Licensed Practical Nurses and Registered Nurses) had required competencies for person centered care, behavior management, medication administration, glucometer testing, handwashing, applying and removing personal protective equipment, enteral nutrition feeding, treatment competency, wound vacuum competency, tracheostomy care competency, nebulizer treatment competency, pain management, intravenous therapy, urinary catheter, and resident rights.The facility policy Staff Development and Inservice Programming, revised 01/18/2023 documented personnel should participate in in-service training to remain current in knowledge which affects the delivery of service with the facility and met Federal and State requirements. The facility (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted education to provide employees with information pertaining to their job function, regulatory, policy, procedural and safety updates, as well as evidence-based practice changes. All staff should attend a series of Mandatory Education annually and as required by state regulations. The facility educator or designee will track employee attendance to ensure required education is attended and required hours of in-service are met.The undated Licensed Practical Nurse/ Registered Nurse Competency Skills Sheet documented topics included Enteral Nutrition Feedings Competency and Personal Protective Equipment Competency.1) Resident #5 had diagnoses including stroke and dysphagia (difficulty swallowing).The 08/30/2025 Minimum Data Set documented the resident was severely cognitively impaired, was dependent for most activities of daily living, and received 26-50% of their total calories through a tube feeding.The 05/20/2025 Comprehensive Care Plan documented the resident required tube feedings for dysphagia. Interventions included to administer tube feeding and water flushes per registered dietitian's recommendation and medical provider's orders: Osmolite (tube feeding formula) 1.2 at 75 milliliters per hour every 12 hours, keep the head of the bed at 30 degrees during administration, and provide local care to the tube site as ordered and monitor for signs and symptoms of infection.The 08/29/2025 physician order documented an enteral feeding order of Osmolite 1.2 via enteral tube at a rate of 75 milliliters to begin at 6:00 PM for a total volume of 900 milliliters to be delivered every 24 hours for neurogenic dysphagia and functional/mechanical obstruction. The hook up was at 6:00 PM and was to be disconnected at 6:00 AM.During an observation on 09/22/2025 at 7:05 AM, Licensed Practical Nurse #29 disconnected the resident's tube feeding from the pole/electronic pump wearing gloves and without wearing a gown. The tube feeing formula bottle was placed in the garbage receptacle with the bottle sitting upright and still connected to the resident's tube feeding line. Licensed Practical Nurse #29 stated they removed the tube feeding so the resident did not have to hear the beeping.During an interview on 09/29/2025 at 1:50 PM, Licensed Practical Nurse #29 stated they could not recall doing any competencies. They received in-services in the facility but none when management observed them. They knew how care for tube feedings due to their experience as a nurse. When disconnecting Resident #5's tube feeding, they wore gloves, flushed the line, took down the tube feeding and threw everything out. The tube feeding bottle should not be connected to the resident when in the garbage. They did not remember taking the resident's tube feeding down on Monday, but they did remember the resident's machine beeping.During an interview on 10/01/2025 at 12:38 PM, Registered Nurse Assistant Director of Nursing #22 stated the process for disconnecting a resident's tube feeding was to put the tube feeding on hold, stop the machine, pinch the tube, cap it, and cover it. It was not acceptable for the tube feeding bottle to be in the trash can while connected to the resident.2) Education and Competencies: Nursing Personnel Education Records were reviewed with the following results:-Licensed Practical Nurse #6 did not have documented evidence of job specific orientation or licensed nurse skills competency. Electronic General Orientation for 2024 was completed 05/20/2025. Computer based cardio-pulmonary resuscitation certification was completed 07/24/2025.-Licensed Practical Nurse #7 did not have any documented education or competencies. -Licensed Practical Nurse #10 did not have any documented education or competencies. -Licensed Practical Nurse #27 did not have documented evidence of job specific orientation, licensed nurse skills competency, or General Orientation. Computer based cardio-pulmonary resuscitation certification was completed 07/24/2025. -Licensed Practical Nurse #29 did not have documented evidence of job specific orientation, licensed nurse skills competency, or General Orientation. Computer based cardio-pulmonary resuscitation certification was completed 07/26/2025.During a telephone interview on 09/23/2025 at 12:41 PM, Licensed Practical Nurse #6 stated after the passing of Resident #85, the facility reviewed staff cardio-pulmonary resuscitation certifications, and the former Director of Nursing and they were the only staff that held a cardio-pulmonary resuscitation certification. They stated they were asked to complete the online training courses and take the exams for other nursing staff and completed them two days after the incident. They completed the training and exam for (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	themself, Licensed Practical Nurse #7, Licensed Practical Nurse #38, and two others.The 09/25/2025 electronic communication from Regional Nurse #41 documented education and competencies were not found for wound care, medication administration, tube feeding administration and care, and nephrostomy care for Licensed Practical Nurses #6, #7, #10, #27, and #29. They identified this as a problem and wrote a performance improvement plan on how to fix the issue. The 09/05/2025 Performance Improvement Summary documented an identified concern with education tracking and documentation. The Assistant Director of Nursing was educated regarding what the required education and competencies were for all new hires. General orientation was assigned to all current staff to ensure that everyone had completed it. All staff would be educated regarding the online education program and the requirements to complete the assignments monthly. Cardio-pulmonary resuscitation certification trackers would be initiated and kept current for better monitoring of staff expiration dates. A competency fair would be set up to get all nursing staff up to date on all competencies. The Learning Management System would be audited weekly to ensure monthly completion of all mandatory education. Competency tracker would be audited monthly to ensure that all new hires have completed the required competencies.There was no documented evidence of education provided to the nursing staff after the facility identified the areas of concern.On 09/29/2025 at 2:47 PM, a voicemail was left for Licensed Practical Nurse #27. They did not return the call prior to survey exit.During a telephone interview on 09/29/2025 at 3:06 PM, Licensed Practical Nurse #7 stated facility trainings were completed on the computer. They did not remember when their last nursing competency was completed. They completed wound vac training when they started employment in 2022. They did wound care training but could not recall when or who provided the training. They had a wound care observation by the corporate team during an audit, but it was over a year ago. They were observed completing a medication pass recently during an audit review of the medication cart, approximately three to six months ago. They received one on one education for tube feed administration and feeding tube care with the unit manager, last year sometime. There a was mock audit completed by corporate a little over a year ago when they were observed providing care and tube feed administration. During a telephone interview on 09/30/2025 at 11:44 AM, Licensed Practical Nurse #10 stated the last nursing competencies were completed with the medication cart audits, a few months ago. The completed wound vac competencies last year. They recently had education for wound care, because they were put on the wound care team for the facility. Audits were done by the corporate team or the Unit Manager. The Unit Manager gave feedback or discussed concerns if any were noted. Hand hygiene education was done every few months when the facility did hand hygiene audits and watched for proper hand hygiene. Tube feed administration and care education was completed when the residents changed. They saw competency checklists, but did not know what was done with them, as the leadership team was consistently changing and no one stayed working there long. During a telephone interview on 09/30/2025 at 12:44 PM, Licensed Practical Nurse #6 stated that they had not received any hands-on competency trainings and only watched videos when they were hired. They had not received any hands-on training regarding wound vacs, no one had ever watched them complete a medication pass, and no one ever observed their hand hygiene practices to ensure competency. They had never received any training/ education on tube feeding administration.During an interview on 10/01/2025 at 12:38 PM, The Assistant Director of Nursing stated they were responsible for nursing education. The education was completed with a sign in sheet, and printed documents for the topic. They read the document and discussed; some trainings had post-tests. Hands on competencies were not done as part of the training. There were competencies to be done annually, many of them were completed on the computer with videos and questions. They had not completed any hands-on competencies with the nursing staff at this time including, wound care, wound vacs, medication administration, and hand hygiene. They recently had completed tube feeding administration, but did not review tube feed dressings. They were unsure where the documented education was, and it was their responsibility to track education. They had not (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed any competencies for nephrostomy tubes as they had not received it themselves. If the nursing staff had not received competencies, they could review policies and procedures in place and staff could ask questions. The facility had recently identified there was an issue regarding staff education and were working on the following topics with PowerPoints, critical/routine laboratory results and reviewing the dashboard (one view of the electronic medical record) so the staff were familiar with it.During an interview on 11/20/2025 at 12:32 PM, the Director of Nursing stated there were concerns about staff training prior to survey. They started at the facility in August 2025 and was not sure when the concerns about training were identified. They were not sure how much education was actually accomplished, but they identified training needed to be done. They asked corporate to send them information to review with staff. The interdisciplinary team had input into the Facility Assessment, the Administrator was responsible for ensuring the form was completed. The Facility Assessment was supposed to outline the education programs based on the needs of the facility. There were certain things that were the core that had to be done, and others were based on the Facility Assessment specifically. They ensured the education program met the needs of the residents based on their invitation to Resident Council. They did not think there were concerns noted for nursing competencies prior to survey. The facility had intravenous devices that were cared for by registered nurses, the nurses were very competent, even though they did not have formal competencies. They had trainings done for respiratory care and wound vacs, but did not know if anything was recorded correctly. They were not sure what the process for education was before they arrived in August, however, they found a form for teachable moments. If they kept noting the same concerns, they should do a house wide training on the topic.During an interview on 11/20/2025 at 1:32 PM, the Administrator stated the Assistant Director of Nursing was responsible for nursing education and documentation of the education. They were supposed to go through and have the competencies associated with the federal regulations throughout the year. They recently conducted a handwashing competency. The Facility Assessment was completed by them, with the assistance from the interdisciplinary team. The education program for the facility should outline the needs of the facility. They ensured the education program met the needs of the residents by completing the Facility Assessment. They reviewed what every specific resident needed and built the best plan of care, to have the best plan they needed to have the education on it.10 NYCRR 415.26(c)(1)(iv)

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	335548	A. Building B. Wing	11/20/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews during the recertification survey conducted 09/22/2025-11/20/2025, the facility did not ensure they established and maintained 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 three (3) of three (3) residents (Residents #5, #43, and #80) reviewed. Specifically, Resident #43's urinary catheter (drains urine from the bladder) collection bag was uncovered and laying directly on the floor without a barrier, and the resident did not have appropriate transmission-based precaution signage posted; Resident #5 was on enhanced barrier precautions and Licensed Practical Nurse #29 did not wear appropriate personal protective equipment when disconnecting the resident's tube feeding; and Certified Nurse Aide #28 did not wear appropriate personal protective equipment when providing direct care to Resident #80 who was on enhanced barrier precautions. Findings include:The facility policy Enhanced Barrier Precautions, revised 3/12/2025, documented enhanced barrier precautions was applicable for residents with a multiple drug-resistant organism (MDRO), any type of wound that required a dressing, and/or an indwelling medical device such as central lines, urinary catheter, feeding tube, or tracheostomy. Enhanced barrier precautions were intended to be in place for the duration of the residents stay or until resolution of a wound or an indwelling medical device and did not require a physician order but could be Initiated or discontinued by the infection preventionist or their designee. Signage would be placed on the door or just outside the door to indicate precautions were in place, the resident's plan of care would be updated to reflect the implementation, and the healthcare provider, staff, resident, and the resident representative were notified and provided education about enhanced barrier precautions. Enhanced barrier precautions required wearing disposable gloves and an isolation gown prior to high resident contact activities such as providing hygiene, transferring, dressing, wound care, device care or use, changing linens, and bathing/showering. The facility policy Catheter Guidelines; Urinary, revised 9/11/2023, documented urinary catheter care and management would follow current infection control prevention and control standards which included emptying the urinary drainage bag regularly to avoid pulling on the tubing and positioning the urinary drainage bag below the level of the bladder but not touching the floor.1) Resident #43 had diagnoses including paraplegia (paralysis of the lower body), osteomyelitis (bone infection) of the left foot and ankle, and an enlarged prostate (causing difficult urination). The 07/28/2025 Minimum Data Set assessment documented the resident was cognitively intact, was dependent with most activities of daily living, and had an indwelling urinary catheter.The Comprehensive Care Plan documented:-on 07/23/2025 the resident had colonized multiple drug-resistant organism. Interventions included to educate resident, family, and visitors on precautions and to monitor for worsening signs and symptoms of infection.-on 7/23/2025 the resident had an indwelling urinary catheter. Interventions included monitor for signs and symptoms of a urinary tract infection, ensure tubing was anchored to prevent pulling, and to maintain the urinary collection bag below the level of the bladder.The Comprehensive Care Plan did not include enhanced barrier precautions. The following observations were made:-on 09/22/2025 at 7:20 AM and 12:06 PM, Resident #43 had no transmission-based precaution signage posted outside their room.-on 09/24/2025 at 11:04 AM, Resident #43 had an enhanced barrier precaution sign posted outside their room. They were lying in bed and their uncovered urinary collection bag contained 1400 milliliters of tea colored urine and was resting directly on the floor. There was no barrier between the collection bag and the floor. At 2:00 PM, Resident #43 was lying in bed and their uncovered urinary collection bag contained approximately 150 milliliters of tea colored urine and was resting directly on the floor. There was no barrier between the collection bag and the floor. The Assistant Director of Nursing, Licensed Practical Nurse #33, and Certified Nurse Aide #35 were standing next to the resident's bed and talking to the resident.During an interview on 09/29/2025 at 3:09 PM, Certified Nurse Aide #35 (continued on next page)

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	335548	A. Building B. Wing	11/20/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they cared for Resident #43 on 09/24/2025 during the day shift. They noticed the resident's urinary collection bag contained brownish colored urine, did not have a privacy cover, and was laying directly on the floor. It should not have been on the floor because the floor was dirty with bacteria. They could not recall if anyone moved the catheter bag off the floor. During an interview on 10/01/2025 at 12:38 PM, the Assistant Director of Nursing stated they were responsible for infection control. They tracked all residents on precautions and ensured they had proper signage, and their isolation carts were full of personal protective equipment. Resident #43 was put on enhanced barrier precautions upon admission. They were unsure why they did not have signage posted outside their room on 09/22/2025 but they thought it could have been moved by another resident. Urinary collection bags should never be placed on the floor, and they did not recall seeing Resident #43's collection bag on the floor on 09/24/2025 or they would have picked it up.During an interview on 10/01/2025 at 1:02 PM, Licensed Practical Nurse #33 stated Resident #43 had a catheter. Urinary collection bags should be covered with a blue bag, kept below the level of the bladder and off the floor. They could not recall if Resident #43's urinary collection bag was on the floor because they did not work at that end of the hallway.During a follow up interview on 10/01/2025 at 1:11 PM, Certified Nurse Aide #35 stated residents with an infection or open wounds were on enhanced barrier precautions and they should have an orange precaution sign outside their room. Resident #43 had a catheter and open wounds but did not have an enhanced barrier precaution sign outside their room on 09/22/2025. On 09/23/2025, an enhanced barrier precaution sign appeared outside the resident's room because the State was there, but no one told them they had to wear a gown.2) Resident #5 had diagnoses including dysphagia (difficulty swallowing), severe malnutrition, and bleeding inside the brain. The 08/30/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition, was dependent for activities of daily living, and had a feeding tube. The Comprehensive Care Plan initiated 5/21/2025 documented the resident was at risk for multiple drug-resistant organism colonization/infections related to a feeding tube (tube inserted into the stomach to provide nutrition). Interventions included enhanced barrier precautions, wear gown and gloves when providing high contact activities at bedside including dressing, changing linens, device care, providing hygiene, wound care, and may wear face protection if there was a risk of splash or spray.The 8/29/2025 physician order documented Osmolite (tube feeding formula) 1.2 via feeding tube at a rate of 75 milliliters per hour to begin at 6:00 PM for a total of 900 milliliters to be delivered. Disconnect at 6:00 AM.During an observation on 09/22/2025 at 7:05 AM, Licensed Practical Nurse #29 disconnected the resident's tube feeding from the pole/electronic pump wearing gloves. They were not wearing a gown. The bottle was placed in the garbage with the bottle sitting upright still connected to the resident's tube feeding line. Licensed Practical Nurse #29 stated they had removed the tube feeding so the resident did not have to hear the beeping.During an interview on 09/29/2025 at 1:50 PM, Licensed Practical Nurse #29 stated they could not recall if they disconnected Resident #5's tube feeding on 09/22/2025. They normally wore just wear gloves when disconnecting the tube feeding and did not wear a gown. The resident was on enhanced barrier precautions so they should have worn gloves and a gown because there was splash back when disconnecting the tube feeding and they had to protect themself. 3) Resident #80 had diagnoses including chronic ulcer of the skin and methicillin resistant staphylococcus aureus (type of bacteria resistant to many antibiotics). The 07/29/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition, was dependent for most activities of daily living, had a diabetic foot ulcer, and one Stage 4 (full thickness skin loss with exposed tendon or bone) pressure ulcer. The Comprehensive Care Plan initiated 10/20/2023 documented the resident had an actual multiple drug-resistant organism infection to wounds related to community acquired methicillin resistant staphylococcus aureus. Interventions included enhanced barrier precautions, wear gown and gloves when providing high contact activities at bedside including dressing, changing linens, device care, providing hygiene, wound care, and may wear face protection if there was a risk of splash or spray.During an observation on 9/25/2025 at 11:44 AM, Resident #80 was lying in bed. There was an (continued on next page)

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	335548	A. Building B. Wing	11/20/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enhanced barrier precautions sign posted outside their room. Certified Nurse Aide #28 entered the room without wearing any personal protective equipment and was carrying a brief, a clean gown, and wash clothes. At 11:45 AM, the certified nurse aide removed the resident's top sheet, threw it on the floor before exiting the room and retrieved gloves. They reentered the room without wearing a gown and shut the door. During an interview on 9/25/2025 at 12:01 PM, Certified Nurse Aide #28 stated they knew a resident was on enhanced barrier precautions because they had a sign outside their room. They were supposed to put on personal protective equipment before they entered the room. They did not think Resident #80 was on enhanced barrier precautions and they were unsure if the enhanced barrier precaution sign outside of the resident's room was for Resident #80 or their roommate because no one told them. During an interview on 10/1/2025 at 12:38 PM, the Assistant Director of Nursing stated if a resident was on enhanced barrier precautions nursing staff was expected to wear personal protective equipment when they provided care which included handling soiled linens from a wound, disconnecting a tube feed, or providing any hands-on care.10NYCRR 415.19(a)(b)

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	335548	A. Building B. Wing	11/20/2025

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations, record review, and interviews during the recertification survey conducted from 09/22/2025-11/20/2025, the facility did not ensure residents were informed during their stay of their rights and rules and regulations governing resident conduct and responsibilities eight (8) of ten (10) residents present at the Resident Group Meeting. Specifically, eight (8) anonymous residents in the resident meeting stated they were not aware of where information on the state complaint hotline, the ombudsman, or other pertinent State agencies were posted; they were not aware of their rights or where they were posted; and the State complaint hotline and other pertinent State agencies and advocacy groups were in small print and not posted at a resident accessible level.Findings include:The facility policy Resident Rights, revised 05/28/2024, documented Federal and state laws guaranteed certain basic rights to all residents of the facility. Residents had the right to communicate with outside agencies (e.g., local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection or advocacy organizations, etc.) regarding any matter. Residents had the right to be informed of their rights and responsibilities in the facility. Copies of resident rights were posted throughout the facility, and a copy was provided to each employee, provider and contracted staff member. Any inquiries concerning the residents' rights were to be referred to the Director of Social Services. During an observation on 09/24/2025 at 8:10 AM the Rights as a Nursing Home Resident document was posted in a locked glass cabinet upon entrance to the north hall. The posting was above standing head height or eye/forehead level and in small print. The complaint hotline and Ombudsman number were also posted above head height. At 8:13 AM the Rights as a Nursing Home Resident, the facility advocacy information, and the ombudsman information were posted in a glass cabinet upon entrance to the south side hall. The posting was above standing head height or eye/forehead level and in small print.During a resident meeting on 09/23/2025 at 2:00 PM, seven anonymous residents stated they were unaware of where the residents' rights were posted in the facility. One anonymous resident stated they asked the Interim Director of Nursing last month about posting the resident rights on both wings and at the front door at a height that was accessible to residents in a wheelchair. Several anonymous residents were not aware of where the state complaint hotline or Ombudsman information were posted.During an interview on 09/30/2025 at 2:04 PM, the Director of Social Work stated they sat in on resident council for the last couple of months. They reviewed resident rights yesterday because a resident asked for a copy of the rights and where they were posted in the facility. The Director of Social Work stated they were unaware of who was responsible for posting the resident rights, Ombudsman information, and state complaint hotline. It was not accessible to all residents if the postings were at eye level at standing height or higher.During an interview on 09/30/2025 at 2:24 PM, the Director of Nursing stated they attended the resident council meeting in August 2025. The residents said they wanted a larger posting of the resident's rights. Resident Rights and other state agency information posted in small print at or above a standing person's eye level was not accessible to all residents; they should be in large print and varying heights. Resident Rights were provided upon admission to the facility, but the resident also received so many other documents at the same time. Resident Rights and other pertinent state contact numbers should be accessible to residents so they knew their rights and they should be able to report complaints or talk to the Ombudsman whenever they wanted to.During an interview on 11/20/2025 at 2:28 PM, the Administrator stated that Resident Rights should be reviewed on admission and yearly at Resident Council.10 NYCRR 415.3