STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335713	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Syracuse Home Association	7740 Meigs Road Baldwinsville, NY 13027

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observations, record review, and interviews during the recertification survey, the facility failed to review the risks and benefits of bed rails with the resident or resident representative, obtain informed consent, and assess the resident for ability to safely use the rails prior to installation of bed rails for one (1) of one (1) (Resident #15) reviewed. Specifically, Resident #15 had bilateral enabler bars/side rails, and there was no documented evidence informed consent was obtained, education was provided, or an assessment was completed for the use of the enabler bars/siderails. Findings include:The facility policy Transfer Bar Policy, last reviewed 10/2025 documented the purpose of the transfer bar was to assist with mobility. A comprehensive assessment must be completed by nursing and/or therapy prior to use. The assessment must evaluate cognitive status, physical strength and mobility, risk of entrapment, ability to use the device safety, and history of falls or injuries. The maintenance staff must inspect the device prior to use and routinely. The residents must be reassessed at least quarterly, with any change in condition, and after a fall safety incident. Resident #15 had diagnoses including Alzheimer's Disease, spinal stenosis (narrowing of spinal canal) and epilepsy (seizure disorder). The 01/13/2026 Minimum Data Set assessment documented the residents had severe cognitive impairment; had functional limitation in range of motion to both arms and legs; was dependent on staff for all activities of daily living; and did not use bed rails. The 10/04/2023 at 1:52 PM Work Order #7462 documented Resident #15 would like a right-side transfer bar on their bed. The request was completed 10/04/2023 at 2:04 PM. There was no documented evidence informed consent was obtained prior to 10/04/2023 when the first enabler bar was placed on the resident's bed. There was no documentation that an assessment was completed to ensure the residents' ability to safely use the transfer bars. The 11/15/2023 at 1:45 PM Work Order #7920 documented the bed in Resident #15's needed the other side rail on for the resident to use. The request was completed on 11/15/2023 at 2:05 PM. There was no documented evidence informed consent was obtained from the resident or the resident's representative related to the use of bed enabler bars/ transfer bars. The 06/17/2024 Comprehensive Care Plan documented the resident required total assistance with activity of daily living tasks. On 10/10/2025, updated interventions included bilateral transfer bars for repositioning. The 01/22/2026 at 6:26 PM Pocket Care Plan documented bilateral transfer bars for safety. There were no documented physician or nursing orders for the bilateral enabler bars. The following observations were made of Resident #15:-on 01/20/2026 at 2:14 PM, in bed with two bilateral enabler bars.-on 01/21/2026 at 1:33 PM, in bed with the two bilateral enabler bars.-on 01/22/2026 at 10:39 AM, sitting in their wheelchair next to their bed with the bilateral enabler bars. During an observation and interview on 01/23/2026 at 1:21 PM, Certified Nurse Aide #1 and Certified Nurse Aide #2 stated the resident required total assistance with their care and could not roll themselves in bed. Staff placed the resident in bed with a Hoyer lift and rolled the resident to their right side. Resident #15 was able to reach the right-side enabler bar with their left hand. When the staff rolled the resident to the left side, the resident could not reach the left enabler bar with their right hand. During an interview on 01/23/2026 at 1:30 PM, Certified Nurse Aide #1 (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident #15 required total care. The resident was fearful during repositioning in the bed, so they had transfers bars placed on the bed about three years ago. The bars were placed on the bed by maintenance. The resident did not roll in the bed independently and required two staff for repositioning. The resident did not use the enabler bar on the left side very well During an interview on 01/26/2026 at 3:25 PM, Registered Nurse Unit Manager #3 stated Resident #15 had transfer bars/enabler bars to hold onto when staff repositioned the resident in the bed. They stated the enabler bars were put on the bed a while ago. The resident was skittish and afraid of rolling out of the bed when being repositioned. They were not sure who ordered the enabler bars for Resident #15's bed. Every quarter the interdisciplinary team met and went over the resident's need for the bars. They did not document the assessments; it was just discussed. They did not have any documentation for education about the risk of the bars or consent for the enabler bars. Maintenance staff placed the enabler bars on the beds when nursing placed a work order notification. During a telephone interview on 01/26/2026 at 12:28 PM, Physical Therapist #4 stated they had not recently evaluated Resident #15 for enabler bars. The last annual screen was 07/2025 and that was a hands-off screen, meaning they received most of the information from the certified nurse aide and licensed practical nurse and documented the resident required total assistance of two staff. They were made aware today, the resident was using enabler bars when in the side lying position to assist with repositioning. They had not evaluated the resident for the use of the enabler bars. Nursing usually made the request for side rails/enabler bars. Therapy would make a formal assessment of the residents for the safe use of the side rails/ enabler bars. Resident #15 had enabler bars since 2023, and the request came from nursing. They were not sure if the consent was completed at that time. Residents with cognitive issues should have their contact person/representative consent to the bars and be educated on the risks and benefits of the bars. During a telephone interview on 01/26/2026 at 12:45 PM, the Director of Maintenance stated Resident #15 had enabler bars placed on their bed on 10/04/2023 and on 11/15/2023. If nursing puts the work order in for the bars, they put them on. They do room inspections annually and those room inspections would include reviewing the resident bed enabler bars for stability and ensuring there were no gaps between the bar and the mattress. During a telephone interview on 01/26/2026 at 12:55 PM, the Director of Nursing stated nursing staff and physical therapy staff worked together to evaluate for the safe use of enabler bars. They were not sure where this was documented. Physical therapy would do most of the documentation because they were responsible for the assessment of the residents' ability to use the bars safely. There should be a referral form in the record, and the interdisciplinary team would meet to discuss the need for the enabler bars. The consent and education for the residents or their contact person should be completed as soon as possible after it was determined the enabler bars were required. They were aware Resident #15 had enabler bars. There were no incidents with Resident #15 related to the enabler bars. 415.12(h)(1)(2)