STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40491 Based on observation, interview, and record review during an abbreviated survey ((NY00295720, NY00298360, NY00298724, NY00300058, NY00300079, NY00300094, NY00301029), the facility failed to ensure each resident had a right to a dignified existence for 3 of 3 meals observed. Specifically, the facility did not consistently provide napkins on trays and used disposable containers and silverware during multiple meal observations. Findings include: The facility policy Resident Nutrition Services/Dining with Dignity, revised 4/2021, documented food and beverages were to be served in non-disposable dishware. The facility policy Meal Tray Pass, revised 1/2022, documented dishes would be utilized unless otherwise ordered by a physician. The following observations were made: - On 7/26/22 at 1:17 PM, a meal tray was observed for temperatures. There was no napkin available on the tray and napkins were not provided during the meal service. - On 7/27/22 at 8:00 AM, the dinner trays from the previous evening remained on the 4S unit. There were disposable to go boxes on all the trays instead of plates. - On 7/27/22 at 10:07 PM, a meal tray was observed for temperatures. There was no napkin on the tray and there was a plastic knife instead of a regular knife. - On 7/27/22 at 12:40 PM, the tray line was observed in the kitchen. From 12:40 PM to 12:45 PM, trays were being plated without napkins. Food Service Supervisor #21 called back to the start of the tray line for napkins to be placed on all trays. At 12:51 PM, Food Service Supervisor #22 was observed at the start of the line and was responsible for putting napkins on the trays. - On 7/27/22 at 9:50 AM, during breakfast on 4S residents used disposable bowls for oatmeal and disposable cups. At 10:33 AM, a replacement tray was brought for Resident #16 in a disposable to go box. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/22 at 10:13 AM, the Food Service Director stated napkins were to be placed on every tray. In the past, they would set up a tray as an example for the staff with missing items such as napkins, and then ask the staff to wipe their mouth or use their napkin as a teaching exercise for staff. Disposable silverware and dishware were not acceptable. The facility had a difficult time obtaining enough knives and cups, and sometimes had to use disposable in place for meal service. The disposable containers for dinner were not acceptable. For breakfast on 7/27/22, the regular oatmeal bowls had been pushed farther down a hallway in the kitchen instead of the usual clean area location. The Food Service Director saw the bowls were available and immediately brought the bowls to the line to switch out; they stated it was a set up issue, the staff should have known they were available, and found them before service. They were not sure what happened on the night shift or what was occurring on the weekend. The residents should have received regular dishware. Sometimes staffing played a role in using disposable containers, but the Director was not notified of any recent staffing issues. The dishwasher was functioning and there was plenty of China available for meal service. Food in disposable containers did not maintain temperatures. 10NYCRR 415.5(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40491 Based on interview and record review during the abbreviated surveys (NY00300094), the facility failed to thoroughly investigate all allegations of abuse, neglect, exploitation, or mistreatment for 1 of 5 residents (Resident #21) reviewed. Specifically, Resident #21 had multiple areas of bruising reported by their health care proxy (HCP) and bruising identified by nurse practitioner (NP) #4 on 7/29/22 which were not thoroughly investigated to determine the cause and to rule out abuse, neglect, or mistreatment. Findings include: The facility policy Investigation - Injuries of Unknown Etiology, revised 11/2019, documented an investigation of all injuries of unknown etiology (including bruises) would be conducted to ensure the safety of the residents had not been jeopardized and to investigate any potential abuse or neglect. The procedure included should a resident be observed with an unexplained injury, including bruises, the staff would report to the licensed nurse on duty who would complete an accident/incident form. The licensed nurse must report the incident or injury to the on-duty Supervisor Resident #21 was admitted to the facility with diagnoses including cerebral infarction (stroke) and epilepsy (a brain disturbance causing seizures). The 7/22/22 Minimum Data Set (MDS) assessment documented the resident had severely impaired cognition, required extensive assistance for most activities of daily living (ADLs), had no falls since admission, and did not exhibit behavioral symptoms. The 7/15/22 Nursing Admission Assessment documented the resident had right iliac crest (hip) and right antecubital (forearm) bruising. The 7/18/22 comprehensive care plan (CCP) documented the resident was at risk for falls related to gait/balance problems, immobility, incontinence, and psychoactive drug use. Interventions included anticipate and meet the resident's needs, be sure the call light was in reach and encourage use, pain evaluation, and physical therapy to evaluate and treat as ordered. The 7/26/22 at 8:00 PM Accident and Incident Report by Assistant Director of Nursing (ADON) #27 documented the resident had an unwitnessed fall in their room from rolling out of their bed. The Accident and Incident report documented there were no injuries. There were no nursing progress notes from 7/26/22-7/29/22 documenting additional areas of bruising. The 7/29/22 nurse practitioner (NP) #4 progress note documented they evaluated the resident for history of a recent falls with multiple areas of ecchymosis (bruising). The resident had areas of ecchymosis on their left forehead, left flank (side) and right scapular (shoulder blade) area, and a bruise to the left inner arm. There was one documented fall, and they suspected the resident had additional falls due to the amount of bruising present. The resident was sent to the hospital for a higher level of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the multiple areas of bruising identified by NP #4 on 7/29/22 were investigated to determine cause and to rule out abuse, neglect, or mistreatment. During a telephone interview on 8/10/22 at 9:19 AM, the resident's HCP stated on admission, the resident had a bruise on their right hip from heparin injections in the hospital. The HCP noticed additional bruising on the resident during their stay which were not present on admission. The HCP reported the new bruising to the nurses and was told the resident was getting up at night to go to the bathroom without ringing for assistance. On 7/29/22, the HCP arrived at the facility at 8:00 AM while a certified nurse aide (CNA) was providing care, and the resident had multiple bruises on their back and arms which had not been previously identified. The HCP spoke with NP #4, who assessed the resident's bruises and stated they would report the bruising to Administration. The resident was sent out to the hospital on 7/29/22 and did not return to the facility. During an interview on 8/11/22 at 10:03 AM, certified nurse aide (CNA) #20 stated they first provided care to the resident on 7/29/22. The HCP came into the room and saw the bruises on the resident's back and stated the resident did not have the bruises before they came to the facility. The resident had bruises on their back and one on their forehead. CNA #20 stated they told RN Unit Manager #55 and social worker #56 about the resident's bruises and the resident went out to the hospital soon after. During an interview on 8/11/22 at 11:29 AM, certified nurse aide (CNA) #42 stated they cared for the resident before they changed rooms on 7/26/22. The CNA stated there were bruises on the resident's back which were present before the resident moved rooms. The CNA asked the nurse about the bruises, and they were told the bruises had already been reported. After the resident moved rooms, they developed a bruise on their forehead. During an interview on 8/17/22 at 1:29 PM, NP #4 stated: - On 7/29/22 the resident had several bruises, and they documented the resident's bruises on their arms, flank, and yellowing on their forehead. They reviewed the resident's record when the HCP notified them of the bruises and found evidence of one fall. The NP stated that the number of bruises the resident had could not have happened from one fall alone. - There was no documentation in the nursing progress notes regarding bruises and the admission assessment documented a bruise on the hip and on the inside of the right elbow, which did not correlate with the bruises identified on 7/29/22. - The NP would expect documentation on bruises as they were considered a change in condition. With bruises, there was a concern of resident to resident interactions, trauma, or that they were inflicted by staff. With the forehead bruises, there was a concern of a head strike which would need to be monitored. - The electronic medical record documented the resident rolled out of bed on 7/26/22 and that was the only documented fall. The NP expected staff to notify the medical provider of any falls and an Incident Report should be completed. - The Incident Report was a tool the facility utilized to prevent future falls and even death. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Without completing Incident Reports, the staff were unable to put preventative measures in place. - The facility staff should have investigated the resident's bruising During a telephone interview on 8/18/22 at 8:18 AM, CNA #51 stated: - They worked with the resident before they moved rooms. The CNA noticed new bruises when providing morning care for the resident. The resident had stated they had fallen overnight, and the staff had helped them off the floor. The first bruise the CNA noticed was on the back before 7/26/22 and they reported the bruises to registered nurse (RN) Manager #55. - The bruise on the back was long. The forehead bruise occurred after the resident moved to the other side of the unit. The CNA noticed more new bruises after the resident's room change. - The resident told the CNA they had been falling overnight, which the CNA reported to RN Manager #55. During a telephone interview on 8/18/22 at 10:40 AM, registered nurse (RN) Manager #55 stated: - If a bruise or a fall was identified, staff were to notify the RN on duty. There should be a skin assessment and a progress note when a bruise was identified. The RN would look at the resident's medications such as blood thinners and if the resident had any recent falls. If they had a recent fall, they would look to see which side of the body the resident fell on for correlation. Bruises did not usually show up on the day of the fall and it usually took a few days for a bruise to present. A fall investigation was a good tracking piece for further falls or new bruises. - The RN had been notified of one fall for the resident. - On 7/29/22, the resident's HCP showed a picture of a bruise on the resident's ear from a previous day during the resident's stay and ADON #8 and NP #4 were called to speak with the HCP - The RN stated they did not recall being notified of any other bruises before 7/29/22, but they may have missed documenting any assessments or bruises. The RN was not aware of the bruise on the resident's back. The resident did have a very small bruise on the forehead, which the RN stated had been related to the fall on 7/26/22. - There should have been a clear, detailed paper trail of everything for the resident and better communication of all parties included, including off shifts. - Incident reports helped to identify fall interventions and could possibly help prevent future falls or injuries from occurring. During a telephone interview on 8/19/22 at 11:02 AM, ADON #27 (evening supervisor) stated: - If a resident had a fall, the staff contacted the ADON who would complete an assessment, start an Accident and Incident Report, and initiate the fall protocol. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- If a resident developed a new bruise, staff would notify the ADON who would assess and initiate an investigation into the source. - The ADON responded to one fall for the resident when they rolled out of bed. At the time of the incident, the resident had no injuries, bruising, or redness noted on their assessment. - If the resident had new bruises, the ADON expected to be notified and they would investigate where the bruise or bruises were coming from. They would make sure the resident was not being mistreated or if something medical was going on. There were multiple concerns with bruising that needed to be investigated to see what was going on. During an interview on 8/22/22 at 11:21 AM, ADON #8 (day supervisor) stated: - If a resident had a newly identified bruise, they expected an investigation into the cause of the bruise to rule out abuse. If a CNA reported to a nurse or RN Manager, the ADON expected an investigation be started and reported to them immediately. - The ADON did not complete an investigation into the bruising after being notified on 7/29/22. They were not aware the resident's HCP or CNAs had previously reported bruising. - The ADON stated if they had heard about the bruises sooner, they would have spoken with RN Manager #55 and asked if the resident had falls. The ADON expected the RN Manager to start an investigation sooner; if the staff had reported bruising to the RN, they should have initiated an investigation and reported it to the ADON. The RN should have documented the bruise in a progress note. - In an ideal situation, the ADON would have liked to have investigated the source of the bruises earlier in the stay. During a telephone interview on 8/22/22 at 11:48 AM, the DON stated: - If a resident developed a bruise or had a fall, they would expect an incident report with staff statements and interviews of the resident's, direct care givers, and staff on the unit for anything that they may have witnessed or been aware of. If the cause of the bruise was unable to be determined, it would be an injury of unknown origin. The point of an incident report and investigation was to rule out abuse, neglect, and mistreatment, and to prevent the development of abuse, neglect, and mistreatment. If the CNA had reported bruising to RN Manager #55, then the RN should have initiated an investigation. An incident report/investigation for falls or bruising should have been done to rule out abuse, neglect, and mistreatment for the resident. If there were no incident reports or investigations, then it was not a thorough investigation. 10NYCRR 415.4(b)(2)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34465 Based on record review and interview during the abbreviated survey (NY00270010), the facility did not ensure a resident received treatment and care in accordance with professional standards of practice for 1 of 2 residents (Resident #33) reviewed. Specifically, Resident #33 had physician orders for blood work and a chest x-rays, the test results returned with abnormal findings and were not reviewed with the physician timely. Findings include: The facility policy Lab Services dated ,d+[DATE] documented the facility provided or obtained laboratory services that met the needs of its residents. Laboratory services would only be provided or obtained when ordered by the resident's physician. Licensed staff made appointments and arrangements with the lab for ordered tests and the resident's physician would be promptly notified of all abnormal test results by telephone or fax. When the physician responded, the response was to be documented in the resident's chart and the test filed in the lab section of the chart. Resident #33 had diagnoses including acute and chronic respiratory failure with hypoxia (low oxygen levels), chronic obstructive pulmonary disease (COPD, blocks airflow), and tracheostomy (artificial airway) status. The [DATE] Minimum Data Set (MDS) assessment documented the resident had intact cognition, required extensive assistance with most activities of daily living (ADLs), had a feeding tube, and required oxygen and tracheostomy care. The [DATE] History and Physical documented the resident had chronic respiratory failure post tracheostomy and frequent hospital admissions for pneumonia. They were appropriate for admission to the facility and needed to concentrate on their pulmonary hygiene in view of recent infections with mucous plugging noted. The [DATE] at 1:03 PM respiratory therapist (RT) progress note documented the resident came back from the hospital unstable with no inner cannula. The resident's oxygen saturation was 90% (normal ,d+[DATE]%) on 10 liters of oxygen per minute and they required suctioning and a nebulizer treatment as stated by EMS (Emergency Medical Service). The oxygen saturation kept declining, and oxygen was increased to 15 liters per minute and the resident was suctioned. The nurse practitioner (NP) assessed the resident and decided to send them back to the hospital. The [DATE] hospital discharge summary documented the facility found the resident hypoxic and the resident was sent to the hospital. After suctioning, their oxygenation improved. Chest x-ray showed pulmonary edema (fluid accumulation) with bilateral effusions (buildup of fluid between the tissue that lines both lungs), bibasilar atelectasis (partial lung/lobe collapse in the base of both lungs) and pneumonia greatest on the left side. The resident was started on antibiotics, intravenous (IV) Lasix (diuretic) and needed frequent suctioning. The resident returned to 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
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] comprehensive care plan (CCP) documented the resident had an alteration in their respiratory system related to COPD. Interventions included administer treatments, observe for signs/symptoms of poor airway clearance and gas exchange, observe secretion color, consistency and odor and report abnormalities to physician, provide oxygen per orders, tracheostomy care daily, suction secretions per physician orders and as needed. The [DATE] at 10:14 PM Assistant Director of Nursing (ADON) #27 progress note documented the resident's trach was plugged and the ADON was unable to pass the suction catheter. The trach was replaced, and the resident was suctioned. The [DATE] at 1:37 PM registered nurse (RN) #55 Manager note documented they were informed by the RT the resident had emesis (vomiting). When they assessed the resident, they were actively vomiting, their lungs had rhonchi (rattling/whistling lung sound), their oxygen saturation was 85% on 4 liters of oxygen. The oxygen was increased to 6 liters per minute. The resident's oxygenation improved to 94% and they were suctioned with good relief. The resident complained of nausea, the NP was notified and ordered blood work and x-rays. The resident did have a recurrent history of aspiration pneumonia (inhaling food/fluid into lungs). The [DATE] physician order documented complete blood count (CBC, blood test), comprehensive metabolic panel (CMP, blood test), chest x-ray (CXR), kidney, ureter, and bladder (KUB, x-ray to assess the abdominal area) to evaluate emesis. The [DATE] untimed radiology report, ordered by NP #4 documented: - Chest x-ray normal: and - KUB, loops of bowel laterally dilated (enlarged) filled with gas. Impression: generalized ileus (temporary slowing of digestive tract mobility). There was no documentation the KUB was reported to the physician. The laboratory results report documented labs were drawn on [DATE] at 11:30 AM and reported to the facility at 3:13 PM. The results were reviewed by RN #55 Manager on [DATE] at 5:39 PM. Results included: - white blood cell count (WBC, blood test for infection) 13.0 microliter (ul) (normal range 4XXX,d+[DATE] ul), creatinine (measures kidney function) 2.25 milligrams/deciliter (mg/dl) (normal range 0XXX,d+[DATE].02 mg/dl), urea nitrogen (measures kidney function) 53 mg/dl (normal range ,d+[DATE] mg/dl). There was no documentation the labs were reported to the physician. There were no documented nursing notes on [DATE] or [DATE]. The [DATE] at 1:14 PM RT #87 note documented the resident stated it hurt to swallow and their chest hurt. Trach care was done, lung sounds had rhonchi, and oxygen saturation was 92%. The [DATE] at 11:49 AM RN #55 Manager note documented the RT reported the resident complained of a sore throat and mid sternal chest discomfort that was worse with breathing. The resident was suctioned of thick yellow secretions, lungs had rhonchi and oxygen saturation was 96%. The NP was notified and ordered a repeat CXR and labs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] physician order documented CBC, BMP (basic metabolic panel), and CXR. The [DATE] laboratory results reported at 6:24 PM, ordered by NP #4 documented: - WBCs 12.1 ul, potassium 5.8 millimoles per liter (mmol/L) (normal range 3.5- 5.1 mmol/L), creatinine 1.94 mg/dl and urea nitrogen 71 mg/dl. There was no documentation the labs were reviewed by a nurse or reviewed with the physician. There was no documentation of CXR results in the resident's record at the time of the abbreviated survey on [DATE]. The [DATE] radiology report, faxed to the facility on [DATE] at 1:04 PM, documented the resident had patchy opacity in the left lower lung that was likely secondary to pulmonary edema, atelectasis and/or pneumonia. The report documented it was originally faxed to the facility on [DATE]. There was no documentation the chest x-ray was reviewed with the physician. The [DATE] at 4:35 AM licensed practical nurse (LPN) #85 progress note documented the resident complained of their trach hurting. The trach was suctioned, and the inner cannula (fits inside trach tube as a liner) was replaced. The resident still complained of pain and the Supervisor was notified. The plan was to continue to monitor. The [DATE] at 6:59 AM RN #86 nursing note documented they were asked to assess the resident's cannula after they complained of discomfort. On arrival, the resident was resting in bed with no pain/distress. The nurse had just given the resident Tylenol. There were no documented nursing notes on [DATE]. The RN Manager #55 progress note dated [DATE] at 8:30 AM documented they were notified by an LPN that the resident was unresponsive, their body was cool to touch, and with no active breathing or pulse. A code blue was initiated, cardiopulmonary resuscitation (CPR, chest compressions/mouth to mouth respirations) performed and automated external defibrillator (AED, analyzes and shocks abnormal heart rhythm) was applied. The NP was at the bedside, emergency medical technicians (EMTs) were called, and the resident was pronounced dead by EMTs at 8:14 AM. On [DATE] at 8:30 AM, LPN #49 stated in a telephone interview they worked the night shift on ,d+[DATE] into [DATE] and was assigned to the resident. They recalled the resident seemed their normal self when they checked on them at on [DATE] at 11 PM. The resident needed to be checked on frequently due to the amount of mucous build up they had from their trach and sometimes needed to be suctioned ,d+[DATE] times during their shift. They recalled suctioning the resident that night but did not recall how many times they did through the night. The last time they saw the resident was around 5 to 6 AM when they gave the resident's roommate medication. The certified nurse aides (CNA) never reported any issues with the resident that night. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:45 AM, ADON #27 stated in a telephone interview staff knew to suction a resident's trach by rounding on the residents and by hearing gurgling noises or by listening to lung sounds. They became aware of lab and x-ray results after the lab or x-ray company called them to report abnormal results. If they received an abnormal report on their shift, they would notify the physician or the on-call provider. The on-call provider then documented a note as well as the nurse who received any orders. On [DATE] at 9:53 AM, NP #4 stated in a telephone interview that residents with a trach were rounded on frequently to assess suctioning needs. The Supervisors had a watch list for resident's that had a trach and Supervisors rounded on them twice a night. If staff needed to report abnormal test results after 5 PM on Friday, there was an on-call provider service available through 8 AM on Monday morning that should be notified. It did not appear the resident's labs and x-rays ordered on Friday [DATE] were addressed with the on-call provider when the results returned. The [DATE] labs showed elevated WBCs and an elevated potassium level, and the x-ray showed patch opacity. Given the resident's history, their increased secretions and underlying COPD, had they been notified of the labs/x-ray results, they would have treated the resident with antibiotics for pneumonia. With the elevated potassium level, they would have ordered a repeat STAT (immediate) potassium level. If the test results were not addressed, it could have contributed to the resident's death as they were having more frequent secretions and increased suctioning needs. The [DATE] at 12:11 AM email from the Director of Nursing (DON) documented there were no physician/provider notes in the resident's record from ,d+[DATE] through [DATE]. There were labs completed on [DATE] in the record though no chest x-ray was found in the record for [DATE]. On [DATE] at 12:45 AM, certified nurse aide (CNA) #83 stated in a telephone interview they were the resident's CNA on the night shift on [DATE]. They were not typically on the resident's unit and would not have recognized if something was wrong with them. If they had noticed something wrong or the resident told them they were not well, they would have reported it. They did not recall who the resident was and could not comment on their condition the night of [DATE]. On [DATE] at 1:23 PM, CNA #84 stated in a telephone interview they worked evening shift on [DATE] and though they did not recall that specific night, they recalled the resident had been acting differently in the week prior to their death. The resident's breathing was off, they were not getting up to use the bathroom, and they had increased phlegm from their trach. Their oxygen levels were occasionally lower than 90%. When lower, the nurses would suction the trach which improved things for a while. They reported their concerns to the nurse though did not recall who. On [DATE] at 11:06 AM, NP #4 was re-interviewed and stated on [DATE], they probably gave a verbal order for labs/x-ray, could not recall if they evaluated the resident, and could not recall if they reviewed the lab results. The labs done on [DATE], showed the resident was most likely developing an infection but the chest x-ray was negative, and they had no temperature so they most likely would not have treated the resident at that time. They were not aware if they got the results of the resident's KUB, the results showed an ileus and at most they would have added a medication to assist with bowel movement though that was not done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:34 PM, RN #55 Manager stated in a telephone interview that lab results were uploaded to the electronic record by the laboratory. During the off shift, the Supervisor was responsible to look for labs in the electronic medical record. If the results were abnormal, the lab called the Supervisor phone to notify them of the results, and they expected the Supervisor to follow up with the physician for further direction. Supervisors were also alerted via email when they came on duty to look for labs drawn that day. The Supervisor should document the abnormal results, and the call to the physician and what the plan was. The facility had been short staffed on Supervisors and sometimes there was only 1 Supervisor for the entire facility, making documentation difficult. On [DATE], they vaguely recalled the day they assessed the resident. On [DATE], they believed they notified NP #4 of the lab results though did not recall what NP #4 stated/ordered and was not sure why they did not write a note. When the [DATE] x-ray showed the resident had an ileus, the Supervisor should have notified the physician and written a note of what the plan was. On [DATE], the Supervisor should have called the physician regarding the abnormal lab and x-ray results. They stated they were not aware the results had not been communicated with the physician. On [DATE] at 1:54 PM, RT #87 stated in a telephone interview on [DATE], when the resident complained of chest pain and had rhonchi, this was not typical for them, and they reported to RN #55 that the resident should be considered for a chest x-ray. They suspected the resident was brewing an infection. 10 NYCRR 415.12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37385 Based on record review and interview during the abbreviated surveys (NY00292089 and NY00297468) the facility failed to ensure residents were free of significant medication errors for 2 of 5 residents reviewed. Specifically, Resident #5 did not receive anti-rejection medication (used after organ transplant) as ordered for 4 days and the physician was not notified. Additionally, Resident #5 did not receive bi-weekly medication for anemia (Aranesp, aids in red blood cell production to reduce or avoid the need for transfusions), the physician was not notified, and the missed Aranesp dose was not rescheduled, the resident was hospitalized due to anemia and required a blood transfusion. Resident #7 was to receive a monthly intravenous (IV) medication that was not provided during their stay at the facility, there was no plan to ensure the resident received it during their stay, and there was no plan for the resident to receive it following their discharge. Findings include: This resulted in actual harm to Resident #5 who developed critical hemoglobin (Hgb) and hematocrit (Hct) lab values and required a transfusion. The facility policy Medication Administration Review revised 8/2019 documented: - Licensed nurses were to ensure that prior to the end of their shift, all medications/treatments administered/held/refused, etc. were properly documented on the Medication Administration Record (MAR). - Failure to do so was considered an omission in the medical record. - The facility would review completion reports during daily clinical meetings for review of potential omissions of documentation. Nursing management would follow up with the nurse within 24 hours to correct documentation if applicable. The facility policy Medication Not Available Guideline revised 1/14/22 documented the licensed nurse on duty was responsible to: - Notify the pharmacy of medication unavailability; - Notify the physician of medication unavailability; obtain the next course of action such as changing next dose time(s), changing medication to what is readily available in-house, pending pharmacy delivery; - If the medication was unavailable from the pharmacy, the facility should obtain alternate physician/prescriber orders; - If the licensed nurse was unable to obtain a response from the attending physician/prescriber in a timely manner, the nurse should notify the nursing supervisor; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0760 Level of Harm - Actual harm Residents Affected - Few	- The licensed nurse should document missed doses on the Electronic Medical Record (EMR) and on the 24-hour report; - Documentation should include explanation of missed dose including actions taken, such as notification of physician to include further orders, adjustment of medication time changes, proposed medication delivery time/day by the pharmacist, third-Party authorization/delivery, assessment/evaluation of the resident related to missed medication; other action to address the missed medication; and - If the medication was not received the nurse should notify the Director of Nursing (DON)/designee and follow up with the physician and pharmacy 1) Resident #5 had diagnoses including iron deficiency anemia (insufficient red blood cells to carry oxygen), end stage renal disease, and post kidney transplant status. The 6/13/22 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, required extensive assistance of one to two for activities of daily living (ADLs), and did not receive any intravenous (IV) medications in the previous 14 days. The 6/9/22 hospital discharge summary documented medication orders including: Envarsus extended release (XR) (tacrolimus, anti-rejection medication for kidney transplant), 1 milligram (mg), take 1 tablet every morning beginning 6/10/22 and continue Aranesp injections. The 6/9/22 physician orders documented: - Aranesp solution 100 micrograms (mcg)/0.5 milligrams (ml), inject 0.5 ml subcutaneously (under the skin) in the morning every 14 days for anemia treatment, start date 6/10/22; - Envarsus XR tablet, 1 mg in the morning, start date 6/10/22. The 6/9/22 Admission/Readmission Evaluation, completed by registered nurse (RN) #72 documented a drug regime review was completed and no potentially clinically significant medication issues were identified since the admission. The 6/9/22 comprehensive care plan (CCP) initiated 6/17/22 documented the resident had anemia/history of anemia. Interventions included monitor and report to the physician signs of anemia and administer medications as ordered. The 6/2022 medication administration record (MAR) documented: - Envarsus XR tablet, 1 mg in the morning, was not administered 6/10-6/13/22 (4 days). The reason code was other/see nurse notes. - Aranesp solution 100 mcg/0.5 ml, inject 0.5 ml subcutaneously in the morning every 14 days for anemia treatment, due 6/10/22 and 6/24/22. The medication was not administered 6/10/22, with the reason code other/see nurse notes. The resident was hospitalized on [DATE] and did not receive the scheduled dose on that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0760 Level of Harm - Actual harm Residents Affected - Few	There were no documented corresponding nursing notes related to the medications that were not administered, no documented evidence the Aranesp administration was rescheduled, and there was no documented evidence the medical provider was contacted when the medications were not administered as ordered. The 6/13/22 at 9:01 AM physician #73's progress note documented the resident was post-renal transplant and the physician had concerns that all the resident's medications may not be in, was not certain how to clarify in the EMR and was to ask the pharmacist consultant to review post-haste (immediately). There was no further documentation in the resident's medical record related to the status of the Aranesp, missed doses, or physician notification. The 6/23/22 laboratory report documented critical results including: - hemoglobin (HGB, protein in blood that carries oxygen) was 6.0 grams per deciliter (g/dL, normal range 12.0-16.0 g/dL); and - hematocrit (HCT, percentage of red blood cells) was 19.2% (reference/normal range was 36-47%). The 6/23/22 at 2:40 PM nursing progress note documented lab results were reviewed with nurse practitioner (NP) #4 with new orders. The 6/23/22 physician order documented to send the resident to the hospital for symptomatic anemia. The 6/29/22 hospital discharge summary documented the resident was admitted on [DATE] and received a blood transfusion. The discharge diagnoses included anemia and cystitis (inflammation of the bladder). The discharge orders included to continue the Aranesp injection. The 6/29/22 physician orders documented: - Aranesp solution 100 mcg/0.5 ml, inject 0.5 ml subcutaneously in the morning every 14 days for anemia treatment, start date 6/30/22. The 6/2022 and 7/2022 MARs documented: - Aranesp solution 100 mcg/0.5 ml, inject 0.5 ml subcutaneously in the morning every 14 days for anemia treatment, due 6/30/22, and was not administered. The reason code was other/see nurse notes. - The next scheduled dose was 7/14/22 (the resident was discharged on [DATE]). There were no documented corresponding nursing notes related to the medication that was not administered on 6/30/22, no documented evidence the Aranesp dose was rescheduled, and there was no documented evidence the medical provider was contacted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0760 Level of Harm - Actual harm Residents Affected - Few	The 7/4/22 at 10:31 AM physician #73's progress note documented the resident returned to the facility after hospitalization for anemia from renal failure for which they received PRBCs (packed red blood cells). The physician noted concern that all the resident's medications may not be in, was not certain how to clarify in the EMR and was to ask the pharmacist consultant to review post-haste. During a telephone interview with pharmacist consultant #75 on 7/28/22 at 2:21 PM, they stated the pharmacy called the facility, communicated through the pharmacy portal, and emailed stating blood work was needed for the Aranesp, and they never received a response. Upon review of the resident's medication record, the pharmacist noted that the Aranesp was not given on the day it was due (6/10/22), and was not rescheduled, as it should have been due to it being a bi-weekly administration. The pharmacist stated Aranesp was for red blood cell production and failure to receive the medication as scheduled could result in loss of red blood cells. On 6/15/22, the pharmacist consultant sent an email documenting potentially clinically significant concerns to the facility and included the Administrator, Medical Director, Director of Nursing (DON), Assistant DONs (ADONs) #8 and 77, and physician #73 stating the resident had not received their Aranesp that was due 6/10/22, it had not been rescheduled and they had not received Envarsus 6/9-6/13/22. Their email included a list of other residents with similar concerns regarding missed/late medications. During a telephone interview with physician #73 on 8/18/22 at 2:00 PM, they stated when they discovered the resident had not received their Envarsus for 4 days, they became concerned as it was needed to prevent organ rejection due to the resident's kidney transplant. The physician expected staff to call them or the on-call provider if a medication was not administered as ordered and they were not notified. The physician stated the resident should not have been discharged from the hospital prior to a weekend with a medication such as Aranesp. They recalled asking for clarification about the medication and could not recall the outcome. When a medication was scheduled bi-weekly and not administered on the day it was due, it needed to be rescheduled rather than waiting for the next scheduled dose. The physician was not certain if the missed dose of Aranesp on 6/10/22 was directly related to the resident's anemia and need for a blood transfusion on 6/23/22. The 8/19/22 email communication from the facility's pharmacy documented: - The order for Envarsus was received electronically on 6/9/22 at 5:59 PM. - On 6/9/22 at 12:52 AM, a pharmacist's note stated the medication was out of stock, the item was ordered, and they spoke to a nurse at the facility. - On 6/14/22, the order was received in stock at the pharmacy and processed for dispensing. - On 6/15/22 at 12:25 AM, the Envarsus was delivered and signed for at the facility. The 8/22/22 email communication from the facility's pharmacy documented: - The order for Aranesp was received on 6/9/22, but valid labs were not received. Multiple attempts were made to inform 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
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0760 Level of Harm - Actual harm Residents Affected - Few	- The pharmacy required hemoglobin and hematocrit values drawn within 28 days of any Aranesp dispense. There was a Black Box Warning associated with all Erythropoiesis-Stimulating Agents (ESAs), including Aranesp, which stated there was an increased risk of death, serious adverse cardiovascular reactions, and stroke when the hemoglobin value exceeds a certain level. - A message was sent via a secured site used for communication between the facility and the pharmacy to clarify on 6/10/22 around 12:37 AM. - The pharmacy followed-up via phone on 6/10/22 around 8:44 AM, and 6/11/22 around 3:23 PM. They were unable to successfully reach anyone. - The request for Aranesp medication was made again via the online messaging system on 6/30/22. Lab values were retrieved, and the medication was processed. - High-cost authorization was required and was received on 07/1/22. - The medication was out of stock on 7/01/22 and was processed and delivered on 07/02/22. During a telephone interview on 8/30/22 at 1:03 PM, licensed practical nurse (LPN) #81 stated there were multiple issues with medications not being available for residents. Resident #5 had medications that were not available when they were admitted . The LPN recalled asking a supervisor if the medications were reviewed prior to admission due to them being high-cost medications that were typically not supported by the facility. This was an ongoing issue at the facility and all the LPN could do was notify the supervisor, as making direct calls to medical providers was discouraged and had to be routed through supervisors. The LPN reported to the supervisor when the Envarsus and Aranesp were not available and was told they were high-cost medications, and they were taking care of it. During a telephone interview with NP #4 on 8/30/22 at 1:21 PM, they stated they were not made aware that Envarsus was not provided for 4 days and that the Aranesp was not administered. When the Aranesp was not administered on 6/10/22, the NP or another medical provider should have been notified to reschedule the medication prior to the next scheduled dose (14 days later). When the resident was hospitalized on [DATE], it could have been related to the missed Aranesp dose, as the medication stimulated red blood cell production, the resident was anemic and required a blood transfusion. When the resident returned on 6/29/22, the Aranesp was due to be administered on 6/30/22 and was not available. When it became available it should have been rescheduled as the next dose was not due until 7/14/22. The RN Managers and DON were responsible for responding to pharmacy inquires and to notify the medical provider of any missed or unavailable medications. During a telephone interview with the Medical Director on 8/30/22 at 2:08 PM, they stated Envarsus was an essential medication, and a medical provider should have been notified when it was not available for administration. When the Aranesp was not administered on 6/10/22, it should have been rescheduled as soon as possible, prior to the next scheduled dose. The RN Manager was responsible to notify the physician to obtain a new dosage schedule. The Medical Director was not made aware of the pharmacy requests for the blood tests. The admitting physician would make the determination of ordering blood work. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0760 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with LPN Manager #82 on 8/31/22 at 2:00 PM, they stated when the resident was first admitted , they were on leave and was unaware of any issues related to the resident's medication availability. When the LPN Manager returned to work, they were not made aware the Aranesp was not administered or received in the facility. Following the resident's hospitalization and return to the facility, the LPN Manager was not made aware the Aranesp was not administered as ordered on 6/30/22. When a medication dose was missed, it was a medication error and the medical provider needed to be notified. The electronic medical record (EMR) would show an alert on the resident's dashboard for 24 hours, which should signal the nurse to notify a supervisor about the medication. When the medication was received on 7/2/22, there was no order to provide it at that time, as the dose was missed on 6/30/22 and not due again until 7/14/22. LPNs were expected to notify a supervisor and not the physician unless there was an issue off-hours. During a telephone interview with the Assitant Director of Nursing (ADON) #77 on 9/1/22 at 9:56 AM, they stated they did not oversee Resident #5's building, ADON #8 was assigned to the floors where Resident #5 resided. When a medication was missed, the nurse was to notify the supervisor, document in the progress notes, and notify the provider. The ADON received the email communications from the pharmacy consultant and stated the ADON assigned to the resident's unit (ADON #8) was responsible to follow up on the issues identified in the emails. ADON #77 recalled the 6/15/22 email from the pharmacy consultant and stated they educated nursing staff on using the online communication system with the pharmacy, documenting missed medications, what they did about it, and provider notification. The ADON stated the lack of documentation related to missed medications was an ongoing issue that she often educated nursing staff about. During a telephone interview with ADON #8 on 9/1/22 at 10:42 AM they stated they were not made aware of any issues related to Resident #5's medications. They were responsible for coverage of the resident's unit and may have overlooked the emails. The proper procedure would be via the pharmacist consultants review reports versus a standard email, as they received hundreds of emails and they may not be able to address them timely. If a medication was not sent from the pharmacy, it would be up to the nurse on the medication cart to address the missing medication, notify the supervisor or nurse manager for further instruction and document accordingly. The nurse manager was expected to notify the medical provider and document in progress notes what was done or to be done. A bi-weekly medication that was not administered needed to be rescheduled by the medical provider. During a telephone interview with the DON on 9/1/22 at 11:06 AM they stated the protocol for a missed or unavailable medication was for the nurse to notify the nurse manager, supervisor or medical provider and document in the medical record. Whenever the pharmacy needed clarification or laboratory results for a medication, they would call the supervisor's phone or send a message through the secured online communication system. Whoever received the information was responsible for follow-up. The DON was not made aware of any issues regarding Resident #5's Aranesp and stated it should have been reviewed with the medical provider to be rescheduled if the doses were missed. When the Envarsus was not available for administration, the nurse should have notified the supervisor or medical provider. Missed medication doses were medication errors due to omission without orders to hold or reschedule the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0760 Level of Harm - Actual harm Residents Affected - Few	2) Resident #7 had diagnoses including dermatomyositis (inflammatory disease with muscle weakness and skin rash) with myopathy (muscle weakness), and myocardial infarction (heart attack). The 2/18/22 Minimum Data Set (MDS) assessment documented the resident had intact cognition, required extensive assistance of 2 for bed mobility, limited assistance of 2 for dressing, toileting, and hygiene, was totally dependent on staff for eating, and did not receive any intravenous (IV) medications in the previous 14 days. The 2/11/22 hospital discharge summary documented IVIG (intravenous immunoglobulin, used were to reduce the effects of some inflammatory conditions that involve the immune system), 130 grams (gm), split as 65 gm daily over 2 days. The last doses were on 2/2/22 and 2/3/22. The 2/11/22 at 3:53 PM nursing progress note entered by registered nurse (RN) #15 documented the resident last had IVIG 130 gm delivered over 2 days in 65 gm doses on 2/2/22 and 2/3/22. The resident received the infusion monthly. They called the pharmacy and were informed IVIG could not be provided to them due to stability issues. The RN called and spoke to the rheumatology office where the resident had an appointment on 3/2/22 and asked if the resident was having the IVIG infusion at this appointment. The resident was not to have the infusion at the appointment and the nurse needed to follow up Monday 2/14/22 on where the infusion can be done. The 2/12/22 History and Physical completed by physician #76 documented the resident had dermatomyositis and IVIG transfusions monthly, 2 g/kg equals 130 gm divided over 2 days, last dosing 1/1/22 and 1/2/22, then 2/2/22 and 2/3/22. The plan included rheumatology consult, follow up for guidance regarding management of dermatomyositis and IVIG infusions. There were no documented nursing or medical progress notes related to follow-up on the IVIG infusions. The 2/28/22 social work progress noted entered by social worker (SW) #56 documented a care plan meeting was held 2/24/22 and discharge was discussed with the resident and their family members via phone. The anticipated date of discharge was 3/8/22. The resident needed an IVIG flush done very soon. The 3/3/22 rheumatologist After Visit Summary documented medication changes that were signed done above each, and needs monthly IVIG infusions 1 gm/kg for 2 days each month with no corresponding notation. The document was initialed by nurse practitioner (NP) #4 on 3/4/22. The next appointment for the rheumatologist was 6/15/22. The 3/3/22 at 9:54 AM nursing progress note entered by RN #74 documented the resident returned from a rheumatology appointment, schedule monthly IVIG 2 doses. The 3/7/22 NP #4 progress note documented all prescriptions e-scribed to the resident's home pharmacy. The 3/7/22 Discharge Summary and discharge orders did not contain any documented evidence of instructions for the IVIG infusion or follow up with the rheumatologist. RN #74 was not able to be reached for interview and no longer worked at 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
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0760 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with RN #15 on 8/2/22 at 11:20 AM, they stated they briefly covered Resident #7's unit as RN Manager and could not recall the outcome for the IVIG transfusion. They stated if there was a question as to arranging the infusion, they would address it with the DON or medical provider, and it should have been documented in the nursing progress notes. During a telephone interview with the Resident's spouse on 8/18/22 at 11:20 AM, they stated the resident was to receive their IVIG treatment on 3/2/22 and 3/3/22 and the facility did not provide it. SW #56 told them the facility would not provide it with no further explanation. When the resident was discharged on [DATE], there was no plan for them to receive the IVIG infusion. The resident was hospitalized on [DATE] after going home and received their infusion at the hospital. SW #56 was not able to be reached for interview and no longer worked at the facility. The 8/19/22 email communication from the facility's pharmacy documented they were unable to locate any orders for IVIG for Resident #7. The 8/22/22 follow-up email communication from the facility's pharmacy documented they were unable to retrieve information related to the phone call from the facility to the pharmacy on 2/11/22 in which the facility was advised the medication could not be provided due to stability. The pharmacy representative stated they were able to provide IVIG on a case-by-case basis depending on the details of the order and available resources at the facility to provide proper administration and monitoring. During a telephone interview with NP #4 on 8/30/22 at 1:35 PM, they stated they did not do IVIG infusions at the facility and it should have been set up for the resident to receive the infusion at their rheumatologist's office or the hospital. The Nurse Manager should have followed up upon finding out it would not be done at the rheumatology appointment. If there was a plan for the resident to receive the infusion following discharge, it should have been addressed in the discharge summary. During a telephone interview with the Medical Director on 8/30/22 at 2:21 PM, they stated the RN Manager should have followed up with the medical provider to ensure the resident was scheduled to receive the infusion. When the resident returned from the rheumatology appointment, NP #4 signed off on the consultation and the Medical Director usually countersigned, and this may not have been done. The facility should have followed up or scheduled the IVIG infusion prior to the resident's discharge. During a telephone interview with the DON on 9/1/22 at 11:06 AM they stated they were not familiar with any issues related to Resident #7's IVIG infusions. They would not be able to provide the infusions at the facility and other arrangements should have been made. When the nurses were made aware it was not given at the rheumatologist's office, the DON expected they would have followed up with the medical provider for further instruction. If the resident was discharged before the plan was made, it should have been included in their discharge plan via follow up appointments to ensure the resident received the needed treatment. 10NYCRR 415.12(m)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40491 Based on observation, interview, and record review during abbreviated surveys (NY00295720, NY00298360, NY00298724, NY00300058, NY00300079, NY00300094, NY00301029), the facility failed to have menus that met the nutritional needs of residents for 3 of 3 meals reviewed and 3 of 3 residents (Resident #25, #30 and #31) reviewed. Specifically, portion sizes were not consistently followed, menu items were missing from meal trays, substitutions were not consistently provided, residents were not notified of substitutions, and fortified pudding was not provided to Residents #30 and 31 residents as planned. Resident #25 stated they did not receive their double portion of red cabbage per their request and tray ticket and were not notified the item was not available. Findings include: The facility policy Menu Substitution, revised 4/2019, documented food substitutions would be made as appropriate and necessary. The Food Service Manager in conjunction with the Clinical Dietitian or Registered Dietitian (RD) could make food substitutions as appropriate or necessary. Deviations from menus which had already been posted would be noted on the menu substitution log form in the kitchen or in the record book used for recording such changes. Menu substitutions must be approved and signed by the Registered Dietitian. All substitutions were noted on the menu. The facility policy Enhanced calorie/Fortified Food, revised 4/2020, documented the licensed dietitian would assess the resident's fluid and nutrition intake and add enhanced calorie or fortified foods when necessary. The dietitian or designee would add the enhanced calorie fortified food to the menu program to schedule the time of administration. Enhanced calorie foods included Magic Cups and fortified puddings; gelatin was not on the list of enhanced or fortified foods. The facility policy Tray Identification, revised 4/2021, documented food service staff would check trays for correct diets before the food carts were transported to their designated areas. Nursing staff would check each food tray for the correct diet before serving the residents. If there was an error, the Nurse Supervisor would notify the Dietary Department immediate by phone so that the appropriate food could be served. The facility policy Honoring Preferences, Making Substitutions, revised 10/2021, documented it was a federal regulation that residents must be offered a nutritional equivalent substitute when foods were refused. It was the resident's right to refuse menu items served and it was dietary's responsibility to recommend a substitute of equal nutritive value. FORTIFIED PUDDING Resident #30 was admitted to the facility with diagnoses including severe protein-calorie malnutrition. The 5/5/22 Minimum Data Set (MDS) assessment documented the resident required extensive assistance with all activities of daily living (ADLs) and did not have a significant weight loss. The cognition section of the MDS was not completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/10/22 comprehensive care plan (CCP) documented Resident #30 had a nutritional problem or potential nutritional problem related to a BMI (body mass index, a measure of body fat) in the lower range; supplements included 4 ounces of fortified pudding at all meals. The 7/28/22 Quarterly Assessment by registered diet technician (DTR) #64 documented Resident #30 had a non-significant down trend in weight over the previous 3 months and their BMI was in the lower range. The meal plan provided fortified foods, including 4 ounces of fortified pudding at all meals. Resident #31 was admitted to the facility with diagnoses including protein-calorie malnutrition. The 4/23/22 MDS assessment documented the resident had severely impaired cognition, required extensive assistance for most ADLs and supervision for eating, and did not have a significant weight loss. The 5/4/22 CCP documented Resident #31 had a nutritional problem or potential nutritional problem related to a significant weight loss of 5.1% in a month on 6/16/22; interventions included one half cup of fortified pudding and Magic Cup (fortified ice cream) at all meals. The 5/6/22 diet technician #65 progress note documented Resident #31 continued with a Magic Cup at all meals, which the resident accepted well. The 6/27/22 DTR #64 progress note documented Resident #31 had a significant weight loss over a month; the resident was to receive fortified pudding three times a day at all meals. On 7/26/22 at 9:50 AM, Resident #31's breakfast was observed; it was missing a Magic Cup and fortified pudding. There was gelatin on the tray that was not documented on the tray ticket. On 7/27/22 at 9:25 AM, Resident #30's breakfast tray was observed and was missing fortified pudding. PORTION SIZES On 7/26/22 at 1:17 PM, a resident's tray was obtained for temperatures and a replacement was ordered. The tray included tuna noodle casserole. The tray ticket documented 6 ounces of tuna noodle casserole and the amount on the plate was less than 6 ounces. On 7/27/22 at 10:07 AM, a resident's tray was obtained for temperatures and a replacement was ordered. The meal included a biscuit with sausage gravy; the biscuit was undersized and measured approximately 2-2 1/2 inches in diameter. MENU NOT FOLLOWED AND SUBSTITUTIONS The 7/26/22 food service Call Back Log documented Room C32 door bed and window bed residents had called down at 11:26 AM. The resident in C32 door bed requested a cheeseburger with extra ketchup and the resident in C32 window bed requested a hamburger with extra mustard. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/26/22 at 1:15 PM, certified nurse aide (CNA) #78 was observed calling down to the kitchen from the C North Unit. The resident in the C32 door bed had received an empty to go box with no cheeseburger. The resident in the C32 window bed had received a cheeseburger with no mustard. CNA #78 stated they had called down earlier and requested two cheeseburgers for each resident. At 1:26 PM, CNA #78 was observed calling down to the kitchen for condiments which were not available on the unit. The 7/26/22 Call Back Log documented C32 D (door) and C32 W (window) requested two cheeseburgers at 1:20 PM. At 1:26 PM, condiments were requested for the C North unit. On 7/27/22 at 12:40 PM, the tray line was observed. The alternate item on the menu was a hot dog on a bun. A tray was observed with a hot dog on a piece of bread. Food Service Worker #63 at the hot station stated there were no hot dog buns available and the tray was served with a hot dog on a piece of bread. Food Service Worker #88 was checking tray accuracy at the end of the tray line; two trays did not have side salads on the tray and was told none were available in the stand-up coolers at the line. Food Service Supervisor #21 looked in the coolers in the kitchen and no salads had been prepared for the meal. The trays were sent to the unit without the side salads. During an interview on 7/27/22 at 3:50 PM, Resident #25 stated cabbage was supposed to be on the menu on a Sunday night and they requested a double portion. They did not receive any cabbage at their meal, and they did not know why. They were often missing meal items such as milk and juices from their tray. During an interview on 8/1/22 at 10:13 AM, the Food Service Director stated serving sizes were part of tray accuracy; the portion size was documented on the tray ticket and staff were to use the correct scoop size or spoodle (portion serving spoon with a long handle with cup-like end specific to the portion size). The Food Service Director was shown a picture of the tuna noodle casserole from 7/26/22 lunch meal and stated that was not the correct portion size. The biscuits were running smaller, and the Director was going to have the RD look at the specs (menu information that would include portion size and expected calorie content) to see what the portion sizes were supposed to be for nutritional adequacy. The Director stated they were able to find hot dog buns; it was a tray line set up error that none were available on the line on 7/27/22 and should have been available. It had been difficult to obtain red cabbage and they had tried to get different types of cabbage such as canned or fresh, but the product was not available. If a menu item was not available, the diet technicians or dietitians were supposed to notify the floors and hopefully the floors would notify the residents. If they ran out of a product during a meal, the supervisor working was supposed to notify the units. The Director did not know if the process was being followed. If a product was not available, the food service staff was instructed to cross out the item on the meal ticket. They had previously made substitutions on the line without asking the Director or dietitian. There was not a shortage of salad, and they should have been made and available for lunch service on 7/27/22. The Director was not aware there were no salads available on 7/27/22 and the tray line should have been set up for salads. An empty to go container was not acceptable. The Director stated it went along with tray line accuracy; if the dietary staff were putting the correct items on the trays, there would be fewer calls to the kitchen. Fortified pudding was available in the kitchen. Gelatin was not an acceptable substitution for fortified pudding, as it was essentially like a fruit punch and did not have the same nutritional value. Residents receiving fortified pudding had a reason for receiving fortified foods and it was not acceptable. 10NYCRR 415.14(c)(1-3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40491 Based on observation, interview, and record review during abbreviated surveys (NY00295720, NY00298360, NY00298724, NY00300058, NY00300079, NY00300094, and NY00301029), the facility failed to provide food and drinks that were palatable, attractive, and at safe and appetizing temperatures for 2 of 2 meals (breakfast and lunch) reviewed. Specifically, a lunch tray with tuna noodle casserole, fortified mashed potatoes, zucchini, biscuit, applesauce, apple juice and a breakfast tray with orange juice and skim milk were not served at palatable temperatures. This is evidenced by: The facility policy Meal Assistance, revised 7/2019, documented hot foods would be kept at temperatures greater than 136 degrees or above and cold foods would be kept at 40 degrees or below until served for all residents. Nursing and Dietary Services would establish procedures such that delivery of food to serving areas would accommodate those requirements. The undated Test Tray Evaluation documented entrees, starches, and vegetables should be greater than 140 degrees Fahrenheit (F) and cold beverages should be less than 41 degrees F. During an observation on 7/26/22 at 1:17 PM, a lunch tray on C North was sampled. The tuna noodle casserole was 109.2 degrees F, the top of the tuna noodle casserole was dark brown, hard, and dried out. The fortified mashed potatoes were 111.3 degrees F and tasted lukewarm. The zucchini was 106.7 degrees F and was mushy, cold, and unpalatable. The biscuit was hard and unable to be bitten into. The applesauce was 65 degrees and not cold to the taste. The apple juice was 62.5 degrees F. During an interview on 7/26/22 at 1:30 PM, Resident #15 stated their lunch was not good and they could not eat anything. The biscuit was so hard, they could not break it apart to have a bite. On 7/27/22 at 10:07 AM, a breakfast tray on 4S was observed for temperatures. The orange juice was 70.5 degrees F, and the skim milk was 56 degrees F. During an interview on 8/1/22 at 10:13 AM, the Food Service Director stated cold foods should be served below 40 degrees and hot foods should be served above 140 degrees F. Temperatures in between were in the danger zone (temperatures where harmful bacteria are most likely to grow) and impacted palatability. Food temperature went towards palatability. For example, apple or orange juice at 50 degrees may not necessarily be harmful, but it should be cool for palatability. The tuna noodle casserole temperature was too low and the hard, browned top impacted palatability. The fortified mashed potatoes and zucchini temperatures were unacceptable and would affect their palatability. A biscuit that is too hard to chew would not be palatable or acceptable. The applesauce, apple juice, milk, and orange juice were not palatable. The breakfast and lunch trays were unacceptable and not the standard. The Food Service Director was showed a picture of the lunch tray. Part of palpability was visual, and people ate with their eyes first, and the tray was not appealing, which could impact resident's meal intakes and nutritional status. 10NYCRR 415.14(d)(2)