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	02/09/2024

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

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48052 Based on observation and interview during the recertification survey conducted 02/5/24-02/9/2024, the facility did not ensure the results of the most recent Federal/State survey were posted in a place readily accessible to residents, family members, and legal representatives of residents. Specifically, the results of the most recent Federal health recertification survey conducted 11/4/2021 were located within a chest of drawers that was not accessible to all residents without asking for assistance. Findings include: The facility policy Resident Rights, reviewed by the facility 10/2023, documented all residents of the facility would have their rights protected and promoted. Every resident would be encouraged and assisted to exercise their rights. The facility policy did not include documentation residents' rights to review the results of the most recent Federal/State survey or that they were posted in an accessible location. During the resident council meeting on 02/05/2024 at 2:18 PM, there were 9 residents present. An anonymous resident stated they knew where the previous survey results were located. However, due to the location they needed to ask for staff assistance to view them. The remaining 8 anonymous residents agreed that staff assistance was required to review the survey results. During an observation and interview on 02/06/2024 at 10:07 AM, a small sign was located at the bottom of the hanging locked glass case that stated, The New York State Department of Health survey results can be found in the chest in the front lobby. Administrative Assistant #7 stated the chest was the drawer set underneath the glass case. The survey results were in a bent folded over plastic dust cover in the top drawer, underneath a cane and two gavels. It was not accessible to residents without requesting assistance. During a follow up interview on 02/8/2024 on 11:18 AM, Administrative Assistant #7 stated the survey book was kept in the chest of drawers and there was a sign in the hanging glass case that indicated to look in the chest for the survey results. They were not aware of any issues of residents not being able to access the drawers, but they would assist residents if needed. They stated they were previously asked for assistance to locate the survey book and were not able to recall if they were asked by residents or visitors. (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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/08/2024 at 11:33 AM, the Social Services Director stated they reviewed where the survey results book was located during every Resident Council meeting. They stated they were not aware of residents having stated they had trouble accessing the survey book. They stated it was understandable that a resident may have difficulty to access to the survey book without assistance because it was in a drawer which could be difficult for some residents to pull open. During an interview on 02/09/2024 10:55 AM, the Administrator stated the summaries of the previous survey results were in the glass case above the chest. The chest contained the actual results of the survey. They believed the results were easily accessible but stated it was subjective. They were not aware residents stated they had to ask for assistance with the drawer to access the survey results. 10NYCRR 415.3(c)(v)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052 48895 Based on record review and interview during the recertification survey conducted 2/5/2024 to 2/9/2024, the facility did not complete or electronically submit encoded, accurate and complete Minimum Data Set (MDS) data to the Centers for Medicare and Medicaid Services System for 65 of 69 residents (Resident #1, 6, 7, 9-11, 13-18, 20-24, 27, 28, 30-39, 41, 43-45, 50-53, 55-59, 61, 62, 64, 66, 67, 70, 176, 182, 183, 186-188, and 373-383) reviewed. Specifically: - Residents #1, 6, 7, 9-11, 13-18, 20-24, 27, 28, 30-39, 41, 43-45, 50-53, 55-59, 62, 64, 66, 67, 70, 176, 182, 183, 186, 373-375, and 377-383 had Minimum Data Set assessments that were electronically submitted greater than 14 days following the completion of the assessment, or not submitted at all. - Residents #23 and #61 had Minimum Data Set (MDS) assessments that were completed later than 14 days following the Assessment Reference Date (ARD). - Residents #187, #188, and #376 had Minimum Data Set (MDS) assessments that were completed later than 14 days following their admitted . Findings include: The 10/2020 facility policy Documentation 9.3 documented that the resident assessment instrument would be completed according to the regulation of Centers for Medicare/Medicaid Services as outlined in [Centers for Medicare/Medicaid Services' Resident Assessment Instrument] Version 3.0 Manual. The most current Minimum Data Set Assessment 3.0 and active Medicare Minimum Data Set Assessment 3.0 for each resident would be filed in the resident record. A written assessment via progress notes by all disciplines (nursing, dietary, activities, resident services, and physical therapy) would be completed on admission, quarterly, annually after three quarterly assessments, and when a significant change was identified. The assessment progress notes should have included information necessary for the completion of the Minimum Data Set 3.0 assessment questions. All assessment progress notes were to be completed by or on the assessment reference date for each Minimum Data Set 3.0 assessment. The schedule for all assessments was created by the Minimum Data Set assessment coordinator. Section Z (Z0500) was signed by the Minimum Data Set assessment coordinator or nurse manager. The completed and locked Minimum Data Set assessment was then submitted to the state by the nursing administrative assistant or Minimum Data Set assessment coordinator. The facility did not have a policy that outlined the minimum data set submission requirements. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Centers for Medicare/Medicaid Services Minimum Data Set Resident Assessment Instrument Version 3.0 Manual documented that comprehensive assessments must be transmitted electronically to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system using the Centers for Medicare/Medicaid Services wide area network within 14 days of the care plan completion date and all other Minimum Data Set assessments must be submitted within 14 days of the Minimum Data Set completion date. For the admission assessment, the Minimum Data Set assessment completion date must be not later than 13 days after the Entry Date. An Omnibus Budget Reconciliation Act assessment (comprehensive or quarterly) was due every quarter unless the resident was no longer in the facility. There must be no more than 92 days between Omnibus Budget Reconciliation Act assessments. During the entrance conference on 2/5/2024 at 9:23 AM, the Administrator stated the facility had a census of 94 with 24 new admissions in the last 60 days. During an interview on 2/6/2024 at 1:29 PM, registered nurse Unit Manager #11, stated if a resident was missing a Minimum Data Set assessment in the electronic record it was because they were on paper in registered nurse/Minimum Data Set Assessment Coordinator #6's office. COMPREHENSIVE ASSESSMENTS: 1) Resident #187 was admitted to the facility on [DATE]. The undated Minimum Data Set assessment, section Z documented verified completion by registered nurse/Minimum Data Set Assessment Coordinator #6 on 2/9/2024 (32 days after admission). 2) Resident #376 was admitted to the facility on [DATE]. The 1/20/2024 Minimum Data Set assessment, section Z documented verified completion by registered nurse/ Minimum Data Set Assessment Coordinator #6 on 2/9/2024 (20 days after admission). 3) Resident #188 was admitted to the facility on [DATE]. The 1/21/2024 Minimum Data Set assessment, section Z documented verified completion by registered nurse/ Minimum Data Set Assessment Coordinator #6 on 2/1/2024 (16 days after admission). QUARTERLY ASSESSMENTS: 1) Resident #23's 1/24/2024 Minimum Data Set assessment, Section Z documented registered nurse Minimum Data Set Assessment Coordinator #6 completed all sections of the assessment and signed the document on 2/9/2024. 2) Resident #61's Minimum Data Set assessment, Section Z was not provided by the facility. MINIMUM DATA SET ELECTRONIC SUBMISSION: (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/8/2024 at 3:44 PM, registered nurse/Minimum Data Set Assessment Coordinator #6 stated there had been problems with the computer system, and the Infection Control nurse had been assisting them with Minimum Data Set Assessments since November 2023. The facility software had been problematic since the Centers for Medicare/Medicaid Services update in October 2023. The facility software was not able to comply with the new assessment requirements. Due to the errors in the facility software, they started completing the Minimum Data Set assessments on paper. There was a specific timeline and due dates for new admissions. The admission assessment would open for entries on day one, they would review clinical data from the hospital, and the Minimum Data Set assessment would open on days 4 through 8, the Care Area Assessments were due by day 14, and the care plan was due by day 21. Quarterly assessments were due minimally every 92 days. The purpose of the Minimum Data Set assessment was to develop the care plan, monitor progress, and meet the needs of the resident. The assessment must be completed within 2 weeks of the Assessment Reference Date or the open date of the assessment. They could not submit any assessments since 10/1/2023. The first batch of assessments for October 2023, were sent electronically on 1/30/2024. They were trying to submit all assessments for 2023 by next week. The expectation was that assessments be submitted within two weeks of completion. The assessments were submitted in batches. They were responsible for batching and submitting Minimum Data Set assessments. The Centers for Medicare/Medicaid Services would become aware of the facilities census; however, they had not been able to submit assessments. Resident #23 had a quarterly Assessment Reference Date of 1/24/2024, and the assessment was not completed as of 2/8/2024, it should have been completed by 2/7/2024. Resident #61 had a quarterly Minimum Data Set Assessment Reference Date of 12/27/2023, it was completed on paper, but they could not locate the document in their office. During a follow-up interview on 2/9/2024 at 9:20 AM, registered nurse/Minimum Data Set Assessment Coordinator #6 stated they did not have documentation of Resident #61's assessment and had to check with another nurse. Resident #187's admission assessment was partially completed in the computer, was completed on paper, but they could not find the paper copy. Resident #376's admission assessment was completed on paper but was not completed timely. Resident #188's admission assessment was completed on paper but was not completed timely. Residents #1, 6, 7, 9-11, 13-18, 20-24, 27, 28, 30-39, 41, 43-45, 50-53, 55-59, 62, 64, 66, 67, 70, 176, 182, 183, 186, 373-375, and 377-383 all had assessments completed on paper, but they were not submitted timely as required. Residents #9, 11, 20, 23, 27, 34, 36, 70, 176, 373, 375, and 378-382 had assessments completed on paper, and the assessments were submitted electronically greater than 14 days after completion. Residents #1, 6, 7, 10, 13-18, 21, 22, 24, 28, 30-33, 35, 37-39, 41, 43, 44, 45, 50-53, 55-59, 62, 64, 66, 67, 182, 183, 186, 374, 377, and 383 had assessments completed on paper, but the assessments were not submitted electronically. During a follow-up interview on 2/9/2024 at 10:30 AM, registered nurse/Minimum Data Set Assessment Coordinator #6 stated the facility had to train the interdisciplinary teams on the new electronic Minimum Data Set assessment before they could use it completely. The new electronic system was set to start in March 2024. Until then, when a new resident was admitted to the facility, the resident's admission assessment was completed in the old electronic medical record and on paper, the nursing notes were completed in the old electronic medical record, and medical orders were reviewed in the new electronic medical record system. The whole process was very fragmented, but it was what they had to do until the new electronic medical record system was fully operational and everyone was trained. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/9/2024 at 10:55 AM, the Administrator stated the vendor they used for Minimum Data Set assessments was not able to comply with the new Centers for Medicare and Medicaid Services updates. They were in contact with the vendor several times between 10/1/2023 and 11/7/2023 and the vendor could not make the system work. The facility received proposal for a new system that went through the quality assessment team. They signed with the new system on 12/26/2023, with the holidays they were able to train the staff and get the old minimum data sets put into the new system on 1/17/2024. They completed 158 submissions in the last week, and stated they had to have all assessments submitted by 2/14/2024. The Administrator stated to their knowledge all the assessments were on time as scheduled. They were unaware that assessment must be submitted within 14 days of completion. During a follow up interview on 2/9/2024 at 1:18 PM, the Administrator stated they did not have a Minimum Data Set assessment policy, the facility used the Centers for Medicare/Medicaid Services manual for guidance. During an interview on 2/9/2024 at 1:47 PM, registered nurse/Minimum Data Set Assessment Coordinator #6 stated Resident #187's admission assessment and Resident #61's quarterly assessment were completed on paper on 2/9/2024, and they were not completed timely. 640 - 10 NYCRR 415.11(a)(5) 636 - 10 NYCRR 415.11(a)(3)(i) 638 - 10 NYCRR 415.11(a)(4)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48052 Based on observation, record review, and interview during the recertification survey conducted 2/5/2024-2/9/2024, the facility did not develop and implement a comprehensive person-centered care plan to meet a resident's medical and nursing needs for 1 of 3 residents (Residentv#66) reviewed. Specifically, Resident #66 did not have a comprehensive person-centered care plan that included a safety gate at the doorway to their room. Findings include: The 9/2023 facility policy Comprehensive Care Plan documented a comprehensive, person-centered care plan would be developed and implemented for each resident consistent with resident rights and include measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. The comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Resident #66 was admitted to the facility with diagnoses including stroke with hemiplegia (one sided weakness) on the non-dominant side, aphasia (difficulty speaking), and dysphagia (difficulty swallowing). The 9/12/2023 Minimum Data Set assessment documented the resident was cognitively intact, required extensive of assistance of two for most activities of daily livings, was non-ambulatory, and did not use restraints. During observations on 2/5/2024 at 11:24 AM and 11:55 AM; 2/6/2024 at 9:59 AM; and 2/7/2024 at 12:47 PM, there was a wooden safety gate across the doorway, latched into the door frame of Resident #66's room. During observations on 2/6/2024 at 8:42 AM and 12:18 PM, there was a wooden baby gate at the doorway of the resident's room that was not pulled across the opening to the room. The 12/5/2023 comprehensive care plan did not document any safety care plans, or use of locking door or baby gate at the resident's room entrance. The psychosocial well-being care plan initiated on 12/19/23 documented the resident was alert, oriented, and able to make their needs known. The 2/5/2024 at 4:44 PM and 2/6/2024 at 5:23 PM, pocket care plan (care instructions) did not document use of a locking door or safety gate at the resident's room entrance. Nursing progress notes dated 10/5/2023 to 2/6/2024, did not document a reason for the use of a safety gate at the entrance of the resident's room. During an interview and observation on 2/5/2024 at 11:55 AM, Resident #66 and the resident's family stated the safety gate at the entrance of the room was used to discourage wandering residents on the unit from entering. The family stated that the resident could not open the gate at the doorway, but the resident was also non-ambulatory, and they could not propel their wheelchair to the door on their own. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/2024 at 12:11 PM, certified nurse aide #2 stated the safety gate had been used for approximately 2 to 3 months. It was used to keep other residents out of the room. The gate was opened by a lift bar in the front, the mechanism pulled upward to unlatch. Resident #66 did not have the strength to open the gate, or ability to reach over the gate to pull up on the bar. During an interview on 2/6/2024 at 12:28 PM, licensed practical nurse #3 stated the pocket care plan was the resident's care plan and was used it to determine the care needs for the residents. They stated the pocket care plan was generated from the computer, but they were not sure how to get to the electronic medical record care plan. They stated it had been a while since they used the electronic medical record care plan. At 12:31 PM, licensed practical nurse #3 stated the safety gate was used keep other residents from going into the room and was provided by the facility. The resident's roommate had an electronic care plan and a paper pocket care plan for the safety gate but Resident #66 did not. During an interview on 2/6/2024 at 1:00 PM, registered nurse #4 stated that other residents wandered into the resident's room, and it upset the resident and their roommate. The resident could not get to the door on their own accord due to their physical limitations. The facility tried to use a stop sign and locking door, without success. The family was very particular about what they wanted for the resident. The safety gate had a bar that lifted on the front and could be pushed in if needed. The unit staff had been trained on using it. Registered nurse #4 stated they were responsible for the nursing portions of the care plans for the residents, but the facility had 2 types of care plans. The main care plan was documented in the electronic medical record, and the pocket care plan was on paper and included basic care required for the resident. The paper care plan could be updated by any licensed staff. Resident #66 did not have a care plan for the safety gate at the door. The roommate did have a care plan for the safety gate, and the 2 residents shared the same doorway. Registered nurse #4 stated Resident #66 should have an electronic care plan and a paper pocket care plan for the safety gate. During an interview on 2/8/2024 at 8:54 AM, social worker #5 stated the Unit Manager and the social worker were responsible for the resident's care plan. The social worker was responsible for the sections in the care plan that included psychosocial needs, mood, and behaviors. There was no care plan area for safety related to the residents. They could include a care plan for safety within any area of the care plan. The safety gate was kept in the common doorway for the resident and their roommate. Resident #66 did not have a care plan for the safety gate and should have. They stated the electronic care plan could not be viewed by certified nurse aides, and frequently froze which made it no longer viewable by anyone. The facility created the paper pocket care plan for ease of access to information that was reviewed daily by nursing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/8/2024 at 11:43 AM, the Director of Nursing stated they expected a resident's care to have all required components and be updated by the interdisciplinary team. The registered Nurse Manager was responsible for the main care plan. The Director of Nursing stated both residents should have been care planned for the safety gate. The lack of a care plan for Resident #66 was an oversight. The safety gate should have been electronically care planned and added to the paper pocket care plan. The electronic care plan and paper pocket care plan did not interface with each other and needed to be updated separately. The current electronic care plan system used was very difficult to navigate and utilize, so the facility developed its own paper pocket care plan. There was a possibility that information went into the electronic care plan but not the paper pocket care plan, and vice versa. The paper pocket care plan was a shortened version of the electronic care plan. The resident's information should be on the electronic care plan first and then moved to the paper pocket care plan. 10NYCRR 415.11(c)(1) 48895

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48052 Based on observation, interview, and record review during the recertification survey conducted 2/05/2024-2/09/2024, the facility did not ensure a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 1 of 1 resident (Resident #33) reviewed. Specifically, Resident #33 did not have their resting hand splint applied appropriately as ordered. Findings include: The facility policy Orthopedic Devices, Care of the Resident With reviewed by the facility 10/2023, documented the nursing staff would apply splints and braces according to the physician's order and under the direction of physical or occupational therapy. The application and removal of the orthopedic device would be monitored by the licensed nurse. Resident #33 had diagnoses including unspecified severe dementia with mood disturbances, personal history of traumatic brain injury, and muscle weakness. The 6/14/2023 Minimum Data Set assessment dated documented the resident had severely impaired cognition, was totally dependent for activities of daily living, and had functional limitation in range of motion in both arms. A 9/22/2023 occupational therapist #16 Therapy Communication Form documented resting hand splint to be donned (applied) after AM self-care and doffed (removed) and doffed at HS (bedtime) and replaced with a palmar pose (hand splint) as tolerated for bedtime. There was a photo that included instructions of how to apply the splint. A physician #15 order dated 11/9/2022 and renewed 12/18/2023 documented left-hand splint on during daytime every day 7:00 AM-3:00 PM. The 12/18/2023 comprehensive care plan documented the resident was at risk for impaired skin integrity and had a left hand contracture. Interventions included a left hand blue palmar posy (hand-splint) on at all times and remove for care. The 2/5/2024 to 2/07/2024 pocket care plans (care instructions) documented a left hand splint was to be applied in the morning. The February 2024 treatment administration record documented the left-hand splint was in place every day. The February 2024 certified nurse aide treatment sheet documented the resident had a left-hand splint applied every day shift from 2/01/2024 to 2/8/2024 except for 2/04/2024 where there was nothing documented. The resident was observed without a left-hand resting hand splint applied or applied inappropriately: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 2/05/2024 at 10:46 AM, sitting in their room in a wheelchair with their left arm curled over their chest and their fingers curled into the palm. The resting hand splint was on the resident's bed, away from the resident. - On 2/07/2024 at 9:14 AM, sitting in their room in their wheelchair with the resting hand splint on their left arm with the straps very loose. Their thumb was off the bracing and curled under. - On 2/08/2024 at 8:53 AM, the resting hand splint was on the resident's lap without the straps on tightly. The resident's forearm and hand were curled into the resident's lap, not on the resting hand splint. During an interview on 2/08/2024 at 9:14 AM, certified nurse aide #12 stated if a resident was gotten up by the night shift, they applied the resident's splint. The day shift certified nurse aide verified it was applied correctly. Therapy educated the certified nurse aides on the splints and there were pictures of how the splint was applied in the certified nurse aide documentation book. They also signed a treatment sheet indicating the splint was applied. Certified nurse aide #12 stated Resident #33's splint was applied by the night shift regularly. They stated the straps on the splint were labeled to ensure correct position and the goal was to keep the left hand open. They stated the resident was unable to remove the resting hand splint themselves. The resident was able to move the splint around slightly by moving around their arm, but the splint should not be completely off the resident. Staff should check the splint periodically to ensure correct positioning. During an interview on 2/08/2024 at 10:24 AM, registered nurse Unit Manager #13 stated splints and contracture management braces were placed on the resident per the physician order. They stated some braces were more complicated than others so therapy would provide education to the staff on how to don and doff the braces. There was a picture of the splint applied to the resident in the certified nurse aide documentation book. The licensed nurses also had a treatment order to check the splints as part of a double check system. Resident #33 could shift their splint with arm movement and the staff should fix it. The straps of the splint should not have been loose enough for their arm or hand to come completely out of the splint when applied appropriately. During an interview on 2/08/2024 at 10:57 AM, licensed practical nurse #14 stated the splints were applied as ordered and licensed nurses documented the splint was applied on the resident in the treatment administration record. They stated Resident #33 could shift the splint. If a certified nurse aide or other staff saw the splint was not on correctly and did not know how to reapply the splint, they should come to them or contact therapy. Therapy would come down and look at the splint. If a resident did not have their splint on, they could become more contracted. During an interview on 2/08/2024 at 11:10 AM, occupational therapist #16 stated if a resident had a specialized splint or if there were questions from the nursing staff, they would provide education. They provided nursing staff a picture of the splint on the resident for reference. They stated Resident #33 had a resting hand splint which should be applied during the day. The resident sometimes maneuvered the brace out of the correct position. The splint would not have been applied appropriately if the straps of the splint were loose enough to still be connected and the resident's hand/arm was not in the splint. If the splint was not applied correctly, the resident could have an increase in tone (increased tension in the muscles which makes it difficult for them to relax). If the splint was being dislodged or taken off a lot, they should be notified so an assessment could be conducted on the continued use of the splint or re-education could be provided to the nursing staff. (continued on next page)

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	02/09/2024

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

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/08/2024 11:43, the Director of Nursing stated the splint devices should be care planned and include directions on how to apply the splint was applied. They stated there was a picture available to the certified nursing aides. The staff should keep track of the splints and have them replaced when dirty. They expected the splints to be applied as care planned per the occupational or physical therapy determination and orders. The nursing staff should notify therapy if the resident was slipping out of their splint so a reassessment could be conducted. Improper placement or application of a splint could cause skin breakdown. 10NYCRR 415.12(e)(2)