STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335427	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oneida Health Rehabilitation and Extended Care	323 Genesee Street Oneida, NY 13421

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37516 Based on record review and interviews during the abbreviated survey (NY00377944), the facility failed to ensure that Advance Directives were implemented in a manner that was consistent with residents' wishes for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 had a physician order for a Full Code (consent to receive life-saving measures in the event of cardiac or respiratory arrest). When the resident was found unresponsive, facility staff failed to timely initiate a Code Blue (signal indicating a medical emergency) and perform cardiopulmonary resuscitation (CPR). Resident #1 was subsequently transferred to the emergency department where they expired. This resulted in Resident #1's death that is Immediate Jeopardy past non-compliance, and likelihood of serious harm, serious injury, serious impairment, or death to all residents in the facility who had Advance Directives in place. Findings include: The facility policy, Advance Directives: Advance Care Planning for Healthcare Decisions, reviewed on [DATE] included: -An Extended Care Facility resident who wished cardiopulmonary resuscitation would have a Full Code order and a heart bracelet placed on them as this would indicate the resident requested cardiopulmonary resuscitation. -Nurses would be checking for cardiopulmonary resuscitation bracelets every shift and initialing in the Medication Administration Record. Resident #1 had diagnoses including chronic respiratory failure and tracheostomy (a surgical opening in the windpipe for breathing). The [DATE] Minimum Data Set assessment documented the resident had severely impaired cognition, received tracheostomy care and continuous high concentration oxygen. Their advance directives were Full Code. Physician orders dated [DATE] included: -CPR: attempt cardiopulmonary resuscitation. -Apply heart bracelet for Full Code. (continued on next page)

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

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident did not have a Medical Orders for Life Sustaining Treatment (MOLST) form. The Comprehensive Care Plan, initiated on [DATE], documented the resident had decided, after making an informed decision, to be a Full Code. The [DATE] Medication Administration Record, documented to check placement of the heart bracelet every shift. The Medication Administration Record was signed on [DATE] by Licensed Practical Nurse #2 during the evening shift and during the day shift on [DATE] by Licensed Practical Nurse #17. The facility investigative summary, dated [DATE] by the Assistant Director of Nursing, documented: - On [DATE] at 10:45 PM, Registered Nurse Supervisor #3 received a call from Licensed Practical Nurse #1 that a resident on the third floor had died . Registered Nurse Supervisor #3 was on their way up to the third floor and at that time received another phone call from the fifth floor (ventilator unit) that there was a Code Blue on a ventilator resident. Registered Nurse Supervisor #3 attended to the resident on the fifth floor. - At approximately 11:30 PM, Registered Nurse Supervisor #3 returned to the third floor. They received the deceased resident's name (Resident #1) and learned the resident was a Full Code.- Registered Nurse Supervisor #3 notified the Director of Nursing the resident was a Full Code, and they advised Registered Nurse Supervisor #3 that a Code Blue needed to be called for Resident #1. A Code Blue was called over the intercom system and cardiopulmonary resuscitation was initiated at approximately 12:07 AM on [DATE]. - Resident #1 was transported to the hospital emergency department (in the same building as the nursing home) where resuscitation efforts continued. - Resident #1 expired on [DATE] at 12:37 AM in the emergency department. - The conclusion of the facility investigative summary documented based on Resident #1's record review and staff interviews, it was determined that although the nurses believed Resident #1 was deceased , they did not act appropriately per policies in place for a Code Blue. A [DATE] at 11:05 PM, Licensed Practical Nurse #1 progress note documented a call was placed to the resident's spouse to notify them resident had expired. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:00 PM, the Director of Nursing stated on [DATE] around midnight, they received a call from Registered Nurse Supervisor #3 that Resident #1 was deceased , was a Full Code, and the two nurses, Licensed Practical Nurse #1 and Licensed Practical Nurse #2, did not initiate cardiopulmonary resuscitation when they found the resident deceased . After Registered Nurse Supervisor #3 called to inform them about the incident, they directed Registered Nurse Supervisor #3 to call a Code Blue and to start cardiopulmonary resuscitation. The Director of Nursing was informed that Licensed Practical Nurse #1 had been told by Certified Nurse Aide #4 that Resident #1 was unresponsive, so they had gone to the resident's room. Licensed Practical Nurse #2 came to Resident #1's room moments later. The Director of Nursing stated that neither of the Licensed Practical Nurses followed protocol for a Code Blue. During interviews for the facility investigation, Licensed Practical Nurse #1 told them they had a lapse in judgment, and Licensed Practical Nurse #2 said they had no explanation as to why they had not started cardiopulmonary resuscitation on Resident #1. Licensed Practical Nurse #2 was at the end of their shift on [DATE] as they worked 3:00 PM - 11:00 PM when Resident #1 was discovered unresponsive, and Licensed Practical Nurse #1 was working 7:00 PM - 7:00 AM on [DATE]. Licensed Practical Nurse #1 and Licensed Practical Nurse #2 were immediately suspended and later terminated from employment at the end of the facility investigation. The Licensed Practical Nurses were reported to the New York State Office of Professions Licensing Board. Since the incident, the facility had done full-house audits on Advance Directives, audits on residents with Full Code bracelets, education of staff on basic life support, cardiopulmonary resuscitation and Code Blue procedure, mock Code Blue drills and cardiopulmonary resuscitation certification/certification renewal classes for staff. During a phone interview on [DATE] at 3:05 PM, Licensed Practical Nurse #1 stated on the night of [DATE], they were in another resident room providing tracheostomy care when Certified Nurse Aide #4 came to them and stated they thought Resident #1 was deceased . Even though Resident #1 was on Licensed Practical Nurse #2's assignment, they were the closest nurse to the room, so they went to Resident #1's room. They saw that the resident's lower extremities were discolored and cool to the touch. They only looked at the resident's right arm for a code bracelet, and did not see one. Licensed Practical Nurse #2 came into the room moments later and agreed that the resident was deceased . They both walked out of the room and Licensed Practical Nurse #1 contacted Registered Nurse Supervisor #3 and informed them Resident #1 was deceased . Later that night they were told by Registered Nurse Supervisor #3 the resident had a code bracelet on their left arm. If they had checked the resident's other arm for a code bracelet they would have started cardiopulmonary resuscitation. During an interview on [DATE] at 3:45 PM, the Administrator stated they were notified immediately of the incident on [DATE] by the Director of Nursing. They expected any staff who were cardiopulmonary resuscitation certified, who came upon an unresponsive resident they would call for help, verify advance directive orders, call a code on the overhead paging system and start cardiopulmonary resuscitation if a resident was a Full Code. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 4:29 PM with Registered Nurse Supervisor #3, they stated they worked the night shift (7:00 PM - 7:00 AM) on [DATE]. All staff were supposed to know what to do in a Code Blue situation. On [DATE] around 10:45 PM, they received a call from Licensed Practical Nurse #1 that a Resident #1 had expired. As they were making their way to the third floor via the elevator to assess Resident #1, they received a phone call from the fifth floor, which was the ventilator unit, informing them they had a Code Blue. At that point, because a Code Blue had not been called on the third-floor resident (Resident #1), and because Licensed Practical Nurse #1 did not state it was emergent, they assumed the resident had the Advance Directive of Do Not Resuscitate (do not perform cardiopulmonary resuscitation). They continued to the Code Blue on the fifth floor and assisted with the transport of that resident to the emergency department. When they finally arrived on the third floor between 11:30 PM - 11:45 PM to assess Resident #1, Licensed Practical Nurse #2 stated the resident was a Full Code (perform cardiopulmonary resuscitation). They called the Director of Nursing and the Medical Doctor around midnight on [DATE] and told them Resident #1 was a Full Code and had not been given cardiopulmonary resuscitation for at least a half hour. The Director of Nursing told them they needed to call a Code Blue and to start cardiopulmonary resuscitation. Respiratory therapy and the rapid response team attempted to resuscitate the resident for about 25 minutes until the resident was transported to the emergency department and pronounced deceased . The last time they were aware the resident was seen by Licensed Practical Nurse #2 was between 9:45 PM - 10:00 PM on [DATE], when they complained of being hot and wanted the window open. The Certified Nurse Aides had discovered the resident unresponsive at 10:45 PM when they were doing their initial rounds, as their shift started at 10:00 PM. Registered Nurse Supervisor #3 spoke with both Licensed Practical Nurse #1 and Licensed Practical Nurse #2 as to why they did not call a Code Blue and start cardiopulmonary resuscitation, and they had no explanation. Licensed Practical Nurse #1 told them they did not think Resident #1 had been wearing a code bracelet on their arm. During a follow-up interview on [DATE] at 9:10 AM with the Administrator, they stated all the licensed nursing staff had been re-educated on basic life support, cardiopulmonary resuscitation, and Code Blue procedures. Certified Nurse Aides had been re-educated as well. There were two (2) certified nurse aides who were per diem that had not received the education yet, but they would be educated upon return to work. During an interview on [DATE] at 10:00 AM with the Medical Director, they stated they were called about Resident #1 by Registered Nurse Supervisor #3 on [DATE] around midnight after the resident had been discovered unresponsive, had been determined to be a Full Code, and cardiopulmonary resuscitation had not been initiated. Resident #1 had probably been deceased an hour or an hour and a half at that point based on what they had been told by Registered Nurse Supervisor #3. The Director of Nursing, Administrator and Registered Nurse Supervisor #3 were all involved in that situation. The expectation for nursing was to follow a resident's Advance Directives order. Any staff with cardiopulmonary resuscitation certification should initiate cardiopulmonary resuscitation on a resident without a pulse who was designated as Full Code. They had no explanation as to why staff delayed starting cardiopulmonary resuscitation on Resident #1. On [DATE] at 11:06 AM, Certified Nurse Aide #4 was called for an interview, and did not return the call. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 11:50 AM with Licensed Practical Nurse #2, they stated the last time they checked on Resident #1 was around 10:00 PM on [DATE] and the resident appeared to be sleeping. They were finishing up their medication pass on one side of the unit when they heard staff calling up the hall around 10:45 PM. They went into Resident #1's room and saw Certified Nurse Aides doing incontinence care on the resident who appeared quite deceased . Licensed Practical Nurse #1 said the resident was deceased . They left the resident's room and went back to doing their nursing tasks on their side of the hall. They checked the resident's code bracelet, and the resident did not have a pulse. They knew the resident was a Full Code. They knew the protocol for a Code Blue, but because Registered Nurse #3 had been called by Licensed Practical Nurse #1, they thought they would take over. Looking back on the situation, once they had determined Resident #1 was a Full Code, they should have called a Code Blue and started cardiopulmonary resuscitation. They were not thinking straight and did not have any further explanation as to why they did not follow the Code Blue protocol. 10NYCRR 400.21(c) _____ Immediate Jeopardy past non-compliance was identified, and the Administrator on Record was notified on [DATE] at 2:36 PM. The facility provided verification the following corrective actions were completed: -Licensed Practical Nurse #1 and Licensed Practical Nurse #2 were suspended immediately following the incident on [DATE]. -Facility policies for Basic Life Support and Cardiopulmonary Resuscitation, Code Blue, Cardiopulmonary Resuscitation Certification, Advance Directives and Determination of Death were all reviewed and completed by [DATE]. -Re-education and staff knowledge competencies of licensed nursing staff and certified nurse aides for Basic Life Support and Cardiopulmonary Resuscitation, and Code Blue Procedure, were initiated on [DATE]. -The facility would add and conduct cardiopulmonary resuscitation and basic life support training to a semi-annual schedule with competencies. -The facility would add and conduct semi-annual cardiopulmonary resuscitation drills across all shifts, initiated [DATE]. -All residents' Advance Directives were audited and completed on [DATE]. -All residents' Full Code (heart symbol) bracelets were audited and completed on [DATE]. -All licensed staffs' cardiopulmonary resuscitation certifications were audited and completed on [DATE]. -All staff present on the unit at the time of the [DATE] incident were interviewed, with interviews completed on [DATE]. (continued on next page)

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