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	01/27/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey (complaint #466496) the facility failed to ensure a resident's designated representative was notified of changes in condition for one (1) of two (2) residents (Resident #175) reviewed. Specifically, Resident #175 was hospitalized , and their designated representative was not notified of their hospitalization.Findings Include:The facility policy Transfer and Discharges. dated 09/16/2016, documented the proper notification of a transfer or discharge would be made to the resident and/or representative. Notification included the reason for the transfer, and the reason would be documented in the resident's clinical record. The facility would provide the resident and/or representative notice of the bed-hold policies and readmission policies prior to the transfer for hospitalization or therapeutic leave. In the case of an emergency transfer, notice at time of transfer meant that the resident representative would be provided with a written notice within 24 hours of the transfer. The resident's copy of the notice would be sent with the resident to the hospital. Resident #175 had diagnoses including acute respiratory failure with hypoxia (low oxygen in the blood), atrial fibrillation (abnormal heartbeat), and hypertensive heart disease with heart failure (long-term high blood pressure that has damaged the heart). The 04/11/2025 physician orders documented:- monitor vital signs every shift. - 75 milligrams of metoprolol tartrate (used to treat high blood pressure and heart failure) twice daily for hypertension.-0.5 milligrams of lorazepam (antianxiety medication) every 8 hours as needed for anxiety.The 04/12/2025 at 4:22 PM, Registered Nurse #28 progress note documented the resident's pulse was 101 beats per minute and was irregular and chronic. The 04/12/2025 at 7:40 PM, Registered Nurse #29 progress note documented the resident's vital signs were taken at 7:30 PM and their heart rate was 153 beats per minute. Registered Nurse/ Nursing Supervisor #30 was notified and provided the resident with metoprolol. At 8:30 PM, the resident's heart rate was 140 beats per minute, and they were provided with lorazepam. At 9:41 PM, the on call medical provider was called. At 9:50 PM, Medical Provider #31 called back and instructed staff to send the resident to the hospital. Registered Nurse/ Nursing Supervisor #30 was notified, and the resident was transferred to the hospital related to tachycardia (increased heart rate). On 04/12/2025 at 10:00 PM, Registered Nurse/ Nursing Supervisor #30, documented the resident was transported to the emergency room per medical provider request related to tachycardia.There was no documented evidence that the resident's designated representative was notified of the resident's transfer to the hospital. During an interview on 01/27/2026 at 2:19 PM, Registered Nurse Unit Manger #4 stated resident representatives should be notified when there was a change in condition, there was no timeframe in which staff should notify the resident representative, but they should be notified the day the change of condition occurred. They were unsure if Resident #175's resident representative was notified when they were sent to the hospital on [DATE]. During an interview on 01/27/2026 at 9:54 AM, Registered Nurse #29 stated they no longer (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worked at the facility, but they recalled the resident was sent out to the hospital for an elevated heart rate and returned to the facility within a couple of hours. They spoke with the medical provider and obtained orders to transfer the resident to the hospital but did not recall speaking with the resident's representative. They also notified Registered Nursing Supervisor #30 about the residents' increased heart rate, and they were sent to the hospital. They were under the impression that Registered Nurse/ Nursing Supervisor #30 was going to notify the representative. Anytime a resident had a change of condition their representative should be notified, and it should be documented in the resident's chart. 10 New York Codes, Rules and Regulations 415.3(f)(2)(ii)(c)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interviews during the recertification survey, the facility failed to ensure each resident received adequate supervision and the environment remained as free of accident hazards as possible for one (1) of six (6) residents (Resident #123) reviewed. Specifically, Resident #123 was at risk of falls, and their call light was not within reach as care planned.Findings include:The facility policy Falls, revised 08/2016, documented on admission, a fall risk assessment would be completed along with a fall care plan with specific individual interventions necessary to prevent resident falls. Fall interventions would be added to resident's care plan, certified nurse aide assignment sheet, and communicated through the 24-hour nursing office report. Nursing supervisors, unit managers, and team leaders would be responsible for ensuring the care plan was being followed.Resident #123 had diagnoses including right side paralysis and weakness and need for assistance with personal care. The 09/12/2025 Minimum Data Set assessment (screening tool) documented the resident had severely impaired cognition, did not have any falls since admission or reentry, and was dependent with dressing, personal hygiene, and bed mobility. The Comprehensive Care Plan initiated 06/05/2025 documented the resident was at high risk for falls related to deconditioning. Interventions included ensuring the residents' call light was within reach, encouraging the resident to use the call light for assistance as needed, and respond promptly to all requests for assistance.The 12/09/2025 Fall Risk Assessment documented the resident had no falls in the past three months, had intermittent confusion, was chairbound and incontinent, and was a fall risk.Resident #123 was observed lying in bed with their call light on the floor under the top part of the bed and not within reach:-on 01/20/2026 at 11:42 AM.-on 01/20/2026 at 1:51 PM.-on 01/21/2026 at 3:19 PM.-on 01/22/2026 at 9:41 AM.-on 01/22/2026 at 3:56 PM.-on 01/23/2026 at 12:48 PM.During an interview on 01/27/2026 at 11:47 AM, Certified Nurse Aide #3 stated Resident #123 was care planned for falls and should always have their call light within reach. They cared for Resident #123 on 01/22/2026 during the day shift and they assisted and rounded on them other days that week. They did not recall seeing the residents' call light on the floor and thought they should put a clip on it, so it did not continue to fall off the bed.During an interview on 01/27/2025 at 12:06 PM, Licensed Practical Nurse #5 stated if a resident was a fall risk it was documented in their orders, on the care plan, and they would have specific fall interventions the staff had to follow for the resident's safety. Resident #123 was a fall risk and care planned for 2-hour checks, a low bed, and to have their call light within reach so they could call for assistance. All staff were responsible for ensuring call lights were within reach. They did not recall seeing Resident #123's call light on the floor but they knew the resident was able to yell out if they needed assistance.During an interview on 01/27/2026 at 12:46 PM, Registered Nurse Manager #4 stated Resident #123 was a fall risk and their fall care plan interventions included ensuring the call light was within reach and prompt response from staff to the call light. All staff who went into Resident #123's room were responsible for ensuring the call light was within reach. They stated if they were aware the call bell was falling onto the floor they would have put a clip on it and attached it to the bed. 10 New York Codes, Rules, and Regulations 415.12(h)(2)