Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335427 | A. Building<br>B. Wing | 04/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oneida Health Rehabilitation and Extended Care | 323 Genesee Street<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>40803<br><br>Based on record review and interview during the recertification survey conducted 4/9/2024 - 4/14/2024 the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for 1 of 3 residents (Resident #229) reviewed. Specifically, Resident #229 remained in the facility after discontinuation of Medicare Part A services and the facility did not provide the resident or resident representative with a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) CMS-10055 (Centers for Medicare and Medicaid Services) for Medicare Part A as required.<br><br>Findings include:<br><br>The CMS form instructions for the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) CMS-10055 (expiration date 1/31/26) documented that a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) CMS-10055 must be issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service - FFS) beneficiaries in situations where Medicare payment was expected to be denied. The SNF ABN must be delivered far enough in advance that the beneficiary or representative had time to consider the options and make an informed choice prior to services ending.<br><br>The facility's 1/31/2022 Medicare Part A Policy (Traditional Medicare) policy documented Medicare A Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) CMS-10055 (Centers for Medicare and Medicaid Services) would be presented to the resident/responsible party two days prior to the last day of coverage and would be notified of the appeal process per regulations for all residents who will be staying long term care.<br><br>Resident #229 was admitted to the facility with diagnoses including left femur (thigh bone) fracture, depression, and cerebral palsy (congenital disorder of movement, muscle tone, or posture). The 2/24/2024 Minimum Data Set Assessment documented the resident had severe cognitive impairment and the assessment was a Skilled Nursing Facility Prospective Payment System Part A discharge (end of stay assessment) with an end date of the most recent Medicare stay of 2/24/2024.<br><br>(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 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | The Skilled Nursing Facility Beneficiary Protection Notification Review documented the resident's Medicare Part A skilled services start date was 1/5/2024 and the last covered day of Part A services was 2/24/2024. The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. A Skilled Nursing Facility Advanced Beneficiary Notice form CMS-10055 (Centers for Medicare and Medicaid Services) was not provided to the resident or resident representative. The explanation as to why the form was not provided documented the resident remained in the facility until 3/12/2024.<br><br>During an interview on 4/14/2024 at 9:20 AM, patient account supervisor #1 stated the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) CMS-10055 Centers for Medicare and Medicaid Services) must be issued within 48 hours prior to the termination of Medicare Part A services. The resident should have been issued the form as they returned to their baseline and remained in the facility until 3/12/2024. They stated the Director of Social Work issued the form to the resident or their representative.<br><br>During an interview with the Director of Social work on 4/14/2024 at 9:30 AM, they stated they thought the business office issued Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage CMS-10055 (Centers for Medicare and Medicaid Services) and did not know if the resident should have been issued the form.<br><br>During a follow up interview on 4/14/2024 at 9:46 AM patient account supervisor #1 stated the resident should have been issued the Advanced Beneficiary Notice of Non-coverage CMS-10055.<br><br>10 NYCRR 415.3(g)(2)(iii) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>49448<br><br>Based on observation, record review, and interview during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not ensure residents' right to privacy and confidentiality of medical records was maintained for 3 of 3 residents (Residents #44, #118, and # 381) reviewed. Specifically, the electronic medication administration records that displayed health information for Residents #44, #118, and # 381 were left open on the medication cart and were visible to passersby in the hallway.<br><br>Findings include:<br><br>The facility policy Patient Confidentiality revised 5/2021 documented every patient would be assured that their right to privacy was maintained and every aspect of their visit was held in strict confidence. Patient information was never disclosed to any unauthorized person (s) without the consent and authorization of the patient or the patient's legal representative (when applicable), except when required by law.<br><br>During a continuous observation on 4/11/2024 from 8:34 AM through 9:07 AM, the Unit 4 medication cart was unattended in the hallway next to the nurse's station. The electronic medication administration record computer screen was open, facing outward, in plain view of passersby, and displayed a photograph and identifying health information for Resident # 381.<br><br>The following observations were made on 4/11/2024 during a medication administration review:<br><br>- at 9:17 AM licensed practical nurse #8 entered Resident #381's room to administer medications and the medication cart was left unattended in the hallway outside of Resident #381's room. The computer screen was left open while licensed practical nurse #8 was in the resident's room. The electronic medication administration record's screen displayed a photograph and identifying health information for Resident #381 and was visible to passersby. Licensed practical nurse #8 returned to the cart at 9:21 AM.<br><br>- at 9:29 AM licensed practical nurse #8 entered Resident #118's room to administer medications and the medication cart was left unattended in the hallway outside of Resident #118's room. The computer screen was left open while licensed practical nurse #8 was in the resident's room. The electronic medication administration record's screen displayed a photograph and identifying health information for Resident #118 and was visible to passersby. Licensed practical nurse #8 returned to the cart at 9:34 AM.<br><br>- at 9:38 AM licensed practical nurse #8 went down the hallway to obtain a blood pressure machine and the medication cart was left unattended in the hallway outside of Resident #44's room. The computer screen was left open, and the electronic medication administration record's screen displayed a photograph and identifying health information for Resident #44 and was visible to passersby. Licensed practical nurse #8 returned to the cart at 9:42 AM.<br><br>(continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - at 9:49 AM, licensed practical nurse entered Resident #44's room to administer medications and the medication cart was left unattended in the hallway outside of Resident #44's room. The computer screen was left open while licensed practical nurse #8 was in the resident's room. The electronic medication administration record's screen displayed a photograph and identifying health information for Resident #44 and was visible to passersby. Licensed practical nurse #8 returned to the cart at 9:52 AM.<br><br>During an interview on 4/11/2024 at 9:52 AM licensed practical nurse #8 stated the computer screen that displayed identifying health information should not have been left open in the hallway. It was a breach of resident privacy. The Health Insurance Portability and Accountability Act protected patient health information from being disclosed. It was not appropriate that passersby could see residents' personal health information. They stated they should not have left the computer screen open when it was unattended.<br><br>During an interview on 4/12/2024 at 2:03 PM the Assistant Director of Nursing stated when medications were administered it was not appropriate for the nurse to leave the electronic Medication Administration Record open in the hallway. There was a button that locked the screen to hide residents' personal health information. If the screen was not locked, they expected the nurse to at least manually flipped the computer screen down, so it was not visible to passersby in the hallway. It was important this information was not displayed in the hallway for patient confidentiality. Confidentiality was important for dignity and quite simply, others did not need to know what was going on with any other person.<br><br>10NYCRR 415.3(d)(1)(ii) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>40803<br><br>44838<br><br>48675<br><br>Based on observation, record review, and interviews during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for 5 of 6 residents (Resident #43, #58, #92, #97 and #102) reviewed. Specifically, Resident #58's care plan did not include the use of a video monitoring device in their room; Resident #43's care plan did not include the use of anticoagulants (blood thinner) or insulin (a medication to control high blood sugar); Resident #102's care plan did not include the use of anticoagulants; Resident #97's care plan did not include the use of antipsychotics (medication used to treat psychosis); and Resident #92's care plan did not include the use of antidepressants or anticoagulants.<br><br>Findings include:<br><br>The facility policy Comprehensive Care Plans revised 4/2024 documented the interdisciplinary team developed a comprehensive, individualized plan of care for each resident that included measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs. The care plan guided the care and treatment provided to each resident. The interdisciplinary team developed the comprehensive care plan in coordination with the physician's plan of medical care. The care plan should be individualized and addressed the residents medical, nutritional, psychosocial, physical, functional, and spiritual needs and the severity of the resident's condition, impairments, disability, or disease. The care plans would be reviewed by all staff that provided care to the resident and updated at least quarterly, when there was a significant change, and as needed.<br><br>1) Resident #58 was admitted with diagnoses including dementia and anxiety. The 2/11/2024 Minimum Data Set Assessment documented the resident had severely impaired cognition, rejected care 1-3 of 7 days, was dependent for dressing, toileting, personal hygiene, and transfers, and received an antipsychotic medication.<br><br>A 10/1/2021 registered nurse #35 progress note documented the resident awoke at approximately 11:55 PM, was screaming, distraught, and saying that they had been sexually assaulted. No one had been in or out of their room. The resident was being checked every 15 minutes and prior to this was sleeping soundly.<br><br>On 10/1/2021 the Chief Medical Officer documented the resident was seen for an evaluation of their endorsement of sexual assault. The resident was recently transferred from the 3rd floor to the 5th floor to be in a private room and closer to the nursing station due to unfound prior complaints of sexual assault. The resident was examined and there were no signs of assault. The case was discussed with the resident's representative. The plan included to reach out to the psychiatrist to address delusions of sexual thoughts, and the representative agreed with placing a video camera in the resident's room for a few days to rule out sexual delusions.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 11/11/2021 comprehensive care plan documented an electronic monitoring optic recording device (camera) was placed in the entry way to the resident's room to track and review comings and goings of staff as needed. Interventions inform family, maintain the dignity of the resident, position the camera in the least invasive manner, and refer to recorded footage as needed to assure the resident that their space was not breached, and they were not abused. On 3/2/2023, social worker #34 resolved (discontinued) the electronic monitoring care plan.<br><br>The undated care instructions did not include documentation of placement of an optic recording device the resident's entry way to their room was monitored via an optic recording device.<br><br>During an observation on 4/9/24 at 11:20 AM the resident was seated in their wheelchair in their room. There was a functioning camera in the corner of the room above their wardrobe facing the opposite wall.<br><br>During an interview on 4/9/2024 at 4:07 PM the resident's representative stated the camera was placed in the resident's room by the facility due to the resident's history of sexual delusions.<br><br>During observations on 4/10/2024 at 8:38 AM and 10:19 AM the resident was in their room. There was a camera in the corner of the room above their wardrobe facing the opposite wall.<br><br>During an observation on 4/11/2024 at 9:35 AM, a computer monitor behind the nursing station was playing live video footage of Resident #58's room. The video footage showed the entryway to the resident's room and the opposite wall was seen. The area of the room from the left side of the bed to the doorway and the bottom 2-3 feet of the resident's bed was also viewed.<br><br>The was no documented evidence the resident's care plan included current video camera monitoring.<br><br>During an interview on 4/11/2024 at 4:26 PM certified nurse aide #27 stated the camera in the resident's room had been there awhile. It was placed due to the resident's history of making allegations of sexual assault. Staff knew the camera was there and did not provide care in the viewing area of the camera and the camera played live footage on a monitor behind the nursing station.<br><br>During an interview on 4/11/2024 at 5:10 PM certified nurse aide #25 stated the camera in the resident's room was used to see who entered and exited the resident's room. The video footage played on a monitor behind the nursing station. The camera was placed in a location it was unable to show when the resident was provided care. The camera was never turned off.<br><br>During an interview on 4/12/2024 at 10:42 AM certified nurse aide #8 stated the camera in Resident #58's room had been in a place for over a year. They thought the camera was on the care instructions.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/12/2024 at 12:06 PM Registered Nurse Unit Manager #3 stated registered nurses initiated the care plans and each department updated their sections as needed. The interdisciplinary team met to review the comprehensive care plans at least quarterly. During those meetings, all areas of the care plan were reviewed and updated as needed. Resident #58 had a camera in their room due to their allegations of sexual assault. It had been put in place prior to them starting on the unit 2 years ago. At one time they remembered a discussion of removing the camera, but it was decided to leave it in place. They stated the camera should be on the resident's care plan, so staff were aware it was in the room to ensure dignity. They were unaware the camera was no longer on the care plan.<br><br>During an interview on 4/12/2024 at 1:25 PM social worker #34 stated the interdisciplinary team met to review the comprehensive care plans at least quarterly. During those meetings, all areas of the care plan were reviewed and updated as needed. Resident #58 did have a camera in their room, and they did not recall resolving the electronic monitoring care plan. They did not write a progress note as to why they resolved the video recording on the comprehensive care plan. It was important for staff to know the camera was in the room to maintain the dignity of the resident.<br><br>During an interview on 4/12/2024 at 2:03 PM Assistant Director of Nursing #4 stated the comprehensive care plans were created by registered nurses and were reviewed at least quarterly or as needed by the interdisciplinary team to ensure interventions remained appropriate and the care areas were accurate. Resident #58 had a camera in their room due to their history of sexual abuse. The camera monitored who was entering and exiting the room. They were unaware the camera usage was no longer on the resident's care plan and should be. It was important for staff to know the camera was in the room to maintain the resident's dignity.<br><br>2) Resident #43 was admitted to the facility with diagnoses including dementia, diabetes, and atrial fibrillation (irregular heartbeat). The 2/6/2024 Minimum Data Set assessment documented the resident had severely impaired cognition and received daily insulin injections and an oral anticoagulant.<br><br>The 1/31/2024 Physician orders documented the resident was to receive:<br><br>- Novolog (short-acting insulin) according to a sliding scale (the amount of insulin administered was based on results of finger stick blood sugar levels) for blood glucose management.<br><br>- Insulin glargine (long-acting insulin) via pen injector twice daily.<br><br>- apixaban (anticoagulant, blood thinner) twice a day for atrial fibrillation.<br><br>There was no documented evidence the resident's comprehensive care plan included the use of insulin or an anticoagulant.<br><br>During an interview on 4/12/2024 at 1:27 PM, registered nurse Supervisor/Staff Development Coordinator #13 stated the admitting nurse did the initial care plan. Insulin should be included in the care plan, so staff were aware to watch for signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). Anticoagulants were not required to be included in the care plan but should be to monitor the risk for bleeding and ensure bleeding precautions and safety razors were implemented. If anticoagulant use was not on the care plan, the certified nurse aides would not know the safety precautions for bleeding should be implemented.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3) Resident #97 was admitted to the facility with diagnoses including dementia with psychotic disturbances, and Parkinson's disease (a progressive disorder of the nervous system). The 1/18/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had no behavioral symptoms, and received an antipsychotic routinely.<br><br>The 3/27/2024 physician orders documented the resident was to receive:<br><br>- Seroquel (antipsychotic) 25mg tablet; 1 tablet in the evening for dementia.<br><br>-Seroquel 25mg tablet; 2 tablets at bedtime for dementia.<br><br>The comprehensive care plan initiated on 10/25/2023 documented the resident had impaired cognitive function related to dementia. Interventions included reviewing medications and recording possible causes of cognitive deficit. The care plan did not include the use of an antipsychotic.<br><br>During an interview on 4/12/2024 at 10:08 AM, licensed practical nurse #9 stated they looked at the resident's care plan to know how to properly care for them. The care plan included activities of daily living and medications the resident was on. They did not have the ability to initiate or update a care plan and if they noticed something was missing, they would notify the registered nurse Manager or Supervisor. They stated if Resident #97's care plan was not updated it could negatively impact them.<br><br>During an interview on 4/12/2024 at 10:12 AM, registered nurse Manager #15 stated all staff should look at a resident's care plan to know how to care for them. The care plan included falls, skin issues, oxygen use, and medications. Medications should be listed in the care plan so staff knew what side effects they should monitor for. Registered nurses were responsible for initiating and updating nursing related care plans quarterly, annually, and as needed. They stated it was important to keep Resident #97's care plan updated because care plans were resident specific and could put the resident at risk if it had wrong information.<br><br>During an interview on 4/12/2024 at 12:33 PM, Assistant Director of Nursing #4 stated care plans were resident specific, and all staff had access to them. Care plans included activities of daily living and medications. If a resident was taking an antipsychotic, anticoagulant, or insulin they expected them to be included in the care plan so staff would know why they were on it and what side effects to monitor for. Registered nurses were responsible for initiating and updating care plans quarterly, annually, and as needed when changes occurred. They stated it was important to keep Resident #97's care plan updated with accurate information so they could be safely cared for.<br><br>10NYCRR 415.11(c)(1)<br><br>49448 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>40803<br><br>Based on observation, record review, and interviews during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 4 of 8 residents (Residents #12, #38, #40 and #58) reviewed. Specifically, Resident #12 had unclean and untrimmed fingernails; Resident #40 was not assisted out of bed for toileting; Resident #58 was not assisted with toileting every 2 hours as care planned; and Resident #38 had unclean fingernails.<br><br>Findings include:<br><br>The facility policy Activities of Daily Living (ADL) revised 10/2023 documented appropriate care and services would be provided for residents who were unable to carry our activities of daily living independently in accordance with the plan of care, including support and assistance with hygiene, mobility, elimination, dining, and communication.<br><br>1) Resident #12 was admitted to the facility with diagnoses including right sided hemiplegia and hemiparesis (paralysis and weakness) following cerebrovascular disease and dementia. The 2/2/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, did not exhibit behavioral symptoms, had upper extremity impairment on one side, required substantial/maximal assistance with showering/bathing, and partial/moderate assistance for personal hygiene.<br><br>The comprehensive care plan revised 7/25/2023 documented the resident required assistance with activities of daily living related to a stroke. Interventions included total assistance of 2 for showering/bathing and extensive assistance of 1 for personal hygiene.<br><br>The 4/2024 resident care instructions (Kardex) documented the resident required total assistance of 2 for showering/bathing, extensive assistance of 1 for personal hygiene, and used a wheelchair.<br><br>Resident #12 was observed:<br><br>- On 4/9/2024 at 10:33 AM, seated in their wheelchair in the hallway. The resident's fingernails were long, unkept, and had a dark brown/black substance under all 10 of their fingernails.<br><br>- On 4/10/2024 at 2:53 PM, seated in their wheelchair in the hallway. The resident's fingernails were long, unkept, and had a dark brown/black substance under all 10 of their fingernails.<br><br>- On 4/11/2024 at 10:15 AM, seated in their wheelchair in front of the nursing station. The resident's fingernails were long, unkept, and had a dark brown/black substance under all their fingernails except for their left thumb nail. At 4:11 PM, the resident's fingernails were long and unkept.<br><br>The 4/11/2024 skin assessment documented the resident received a shower during the day shift, their skin had no open areas, and their fingernails were not trimmed.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/11/2024 at 5:02 PM, certified nurse aide #14 stated certified nurse aides were responsible for resident showers. On shower days they completed nailcare, hair care, and the resident's skin was assessed by the nurse. If the resident was a diabetic the nurse was responsible for cutting their nails. They stated Resident #12 never refused care and they gave them a shower during the day shift. They could not recall if they trimmed their nails. The stated it was important to perform personal hygiene and to keep Resident #12's fingernails from getting too long for resident safety.<br><br>During an interview on 4/11/2024 at 5:11 PM, licensed practical nurse #9 stated Resident #12 received their weekly shower that morning. Certified nurse aides were responsible for trimming fingernails on shower days. During a shower the certified nurse aide would turn on the call light so the nurse could go in and do a skin check. They documented their skin and nail findings in a skin assessment in the electronic medical record. They stated Resident #12 did not refuse care or showers. Licensed practical nurse #9 observed Resident #12 during the interview and stated they needed their nails cut. They stated having long fingernails placed Resident #12 at risk for cutting themselves or someone else, and it was not sanitary to have a dark substance under their nails.<br><br>During an interview on 4/12/2024 at 10:29 AM, Registered Nurse Manager #15 stated on shower days certified nurse aides were expected to cut residents' fingernails. Resident #12 received their shower on 4/11/2024 so their nails should have been cleaned and trimmed. They stated it was important to keep Resident #12's nails clean, trimmed, and filed for safety. If the resident received a cut, it could have led to an infection.<br><br>During an interview on 4/12/2024 at 12:38 PM, Assistant Director of Nursing #4 stated staff should look at the resident's care plan and care instructions to know how to care for the resident. On shower days the certified nurse aide was responsible for haircare, nail care, and grooming. If a resident was a diabetic the licensed nurse would complete the nail care. If Resident #12 had long/dirty fingernails, they expected staff to notice and take care of it. If there was no documented refusal, there was no reason it should not have been done on the resident's shower day. They stated it was important to keep nails cleaned and trimmed for infection control purposes. Long fingernails put Resident #12 at risk for cutting themselves or others.<br><br>2) Resident #40 had diagnoses including compression fracture of the thoracic vertebrae (mid-spine), muscle weakness, and need for assistance with personal care. The 1/10/2024 Minimum Data Set documented the resident was cognitively intact, required substantial/ maximum assistance with toileting, was frequently incontinent of bowel and bladder, and did not reject care.<br><br>The comprehensive care plan initiated on 6/21/2023 and revised on 7/19/2023 documented the resident has functional nocturnal (nighttime) bladder incontinence related to weakness. Interventions included monitor toileting scheduled every 2 hours, take resident to bathroom before bedtime and at 3:00 AM. The comprehensive care plan initiated 11/3/2023 documented the resident had an activity of daily living deficit related to weakness. Interventions included the resident was dependent on toileting and required extensive assistance of 2 for transfers with a sit to stand lift (mechanical lift).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335427 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/12/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Oneida Health Rehabilitation and Extended Care | | STREET ADDRESS, CITY, STATE, ZIP CODE: 323 Genesee Street Oneida, NY 13421 | |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 4/9/2024 at 11:17 AM, Resident #40 was lying on their back in bed. The resident stated they would like to get out of bed a couple of times a week, but they needed assistance of 2 and there was not enough staff, so they did not get out of bed. They stated staff did not let them go into the bathroom because they fell approximately 6 months ago in the bathroom. Now they had to use an incontinence brief in the bed when they needed to urinate and then ring the call bell for staff to come and change the brief. They stated they had not gotten up to go into the bathroom at all since they fell 6 months ago. They stated they knew when they needed to urinate and would often ask for a bedpan when they had to defecate. They stated they would prefer to get up and go into the bathroom.<br><br>Resident #40's care instructions (Kardex) as of 4/12/2024 documented the resident required a mechanical sit to stand life with extensive assistance of 2 for transferring and was dependent for toileting. The resident's voiding routine documented to take the resident to the bathroom before bedtime, wake the resident at 3:00 AM to take to the toilet.<br><br>During an interview on 4/12/2024 at 12:46 PM certified nurse aide #24 stated Resident #40 required assistance of 2 with the sit to stand lift. The resident usually urinated in their brief but would ask for a bedpan for a bowel movement. The resident told them when they were wet and needed to be changed. Residents should be encouraged to function at their highest level. They stated the resident was afraid to fall and afraid to get out of bed, because staff would not get them back into bed timely.<br><br>During an interview on 4/12/2024 at 12:59 PM licensed practical nurse #21 stated the certified nurse aides followed the level of care on the Kardex for toileting. They stated if a resident was able to get out of bed they should. Lying in urine or feces could contribute to skin irritation and breakdown. They had never seen Resident #40 out of bed.<br><br>3) Resident #58 had diagnoses including dementia, need for assistance with personal care, and anxiety. The 2/11/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, rejected care 1-3 of 7 days, was dependent with toileting, hygiene, and toilet transfers, was on a toileting program to manage urinary continence, was frequently incontinent of bladder, and received a diuretic (water pill).<br><br>The 12/11/2019 comprehensive care plan documented the resident had an activity of daily living self-care performance deficit due to disease process. Interventions included extensive of assistance of 2 with toileting from 9:00 AM-10:00 AM following their diuretic, and then every 2 hours and as needed. The resident required extensive assistance of 2 using a mechanical stand lift to move between surfaces.<br><br>The revised 1/16/2024 comprehensive care plan documented the resident was at risk for skin breakdown related to decreased mobility and occasional incontinence. Interventions included monitoring skin.<br><br>The 2/10/2024 physician orders documented the resident received 20 milligrams of torsemide (diuretic) one time a day every other day.<br><br>The undated care instructions (Kardex) documented the resident required extensive assistance of 2 with toileting via mechanical stand lift and was to be toileted every 2 hours and as needed.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The 4/11/2024 6:00 AM-2:00 PM unit assignment sheet documented certified nurse aide #25 was responsible for assignment one, which included Resident #58.<br><br>On 4/11/2024 certified nurse aide #25 documented Resident #58 was toileted every 2 hours at 7:58 AM, 8:07 AM, 10:39 AM, and 1:40 PM.<br><br>During an observation on 4/11/2024 at 11:12 AM, Resident #58 returned to the unit from an off-unit activity and self-propelled their wheelchair into their room. At 12:34 PM, the resident remained in their wheelchair in their room. At 12:48 PM, the resident was provided their meal tray in their room by an unidentified staff. At 1:18 PM, an unidentified staff removed the resident's meal tray from their room. At 2:21 PM, an unidentified activity staff asked the resident if they wanted to go off the unit to an activity which they declined. At 2:30 PM, the resident had not been provided toileting assistance since returning to the unit at 11:12 AM.<br><br>During an interview on 4/11/2024 at 4:36 PM, licensed practical nurse #26 stated they started working on the unit that morning at around 11:00 AM. They expected staff to reapproach any resident who refused care and let the nurse know. If staff was unable to provide care, they should let the nurse know as well so they could help or find additional help. If they were made aware staff was unable to provide care, they would let a supervisor know. They stated they were not aware of any residents who did not receive care today.<br><br>During an interview on 4/11/2024 at 5:10 PM, certified nurse aide #25 stated staff reviewed the care instructions which let staff know what level of assistance the residents required and any special instructions. If the care instructions documented the resident required extensive assistance of 2 that meant 2 people were needed to provided care and staff did most of the task for the resident. They could not recall what assignment they were scheduled today but they were familiar with Resident #58. They were unsure if the resident was on a toileting program and the resident was usually continent and could tell staff if they needed to use the bathroom. The resident usually required extensive assistance of 2, but sometimes could be extensive assistance of 1. They knew they charted wrong, and the only care they provided besides passing them their meal tray was toileting assistance around 7:30 AM. Prior to that the resident was going to an activity off the unit in the morning. They stated staff was supposed to follow the care plan and at least ask the resident if they needed to use the bathroom. They did not tell anyone that they did not place the resident on the toilet or ask them if they needed to use the bathroom.<br><br>During an interview on 4/12/24 at 12:06 PM, Registered Nurse Unit Manager #3 stated staff was expected to follow the care plan and care instructions. If they were unable to provide care, they should alert a nurse so care could be provided. If a resident was on a toileting program staff should check to ensure the resident did not need to be changed or brought to the bathroom. If a resident was care planned for extensive assistance of 2 that meant 2 staff members should have been in the room to provide care for safety reasons. Resident #58 was on a 2-hour toileting program and required extensive assistance of 2 with transfers and toileting. They were unaware the resident had not been provided toileting assistance as care planned. The resident had very fragile skin and 4 hours was a long time to go without being assisted to the bathroom.<br><br>(continued on next page) |

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|---|---|---|---|
| | 335427 | A. Building<br>B. Wing | 04/12/2024 |

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

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/12/2024 at 2:03 PM, Assistant Director of Nursing #4 stated staff should always follow the care plan. If a resident refused care or staff were unable to provide care, they should let a nurse know. If a resident was on a toileting program staff should have at least asked the resident if they needed to use the bathroom. 4 hours was a long time to go without being assisted to the bathroom. It was important to follow the care plan, so the resident's abilities did not diminish.<br><br>10NYCRR 415.12 (a)(3)<br><br>48675<br><br>49448 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44838<br><br>Based on observation, record review, and interviews during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not ensure residents were provided an ongoing program to support their choice of activities, designed to meet their interests and support their physical, mental, and psychosocial well-being for 2 of 3 residents (Residents #40 and #79) reviewed. Specifically, Residents #40 and #79 were not provided meaningful activities that met their interests and preferences.<br><br>Findings include:<br><br>The facility policy Activities revised 3/2019 documented the main purpose of the activity program was to enable the individual to continue to enjoy the experience of life and to enable the individual to participate successfully in whatever pursuits they preferred. Pursuits included recreational, spiritual, intellectual, and other activities which were basic to a balanced and rewarding life.<br><br>The April 2024 Activity Calendar documented:<br><br>-On 4/9/2024: at 8:15 AM Talk to Me, at 10:00 AM BINGO in the central dining room, at 11:30 AM unit visits, at 2:30 PM [NAME] the Riveter in the central dining room, at 3:30 PM card club in the central dining room, and at 5:00 PM individual visits on the 3rd floor.<br><br>-On 4/10/2024: at 8:15 AM Good Morning Greetings, at 10:00 AM morning stretch on units 3, 4, and 5, at 11:30 AM unit visits, and at 2:00 PM movie in the central dining room.<br><br>-On 4/11/2024: at 8:15 AM Boredom Buster, at 10:00 AM BINGO in the central dining room, at 2:30 PM paper tulips in the central dining room, and individual pet visits, and at 5:00 PM [NAME].<br><br>-On 4/12/2024: at 8:15 AM Daily Chronicles, at 10:00 AM Crazy Cooking in the central dining room, at 11:30 AM unit visits, and at 2:30 PM Happy Hour.<br><br>1) Resident #40 was admitted to the facility with diagnoses including macular degeneration (a disease affecting vision), glaucoma (a disease that causes vision loss and blindness), and difficulty walking. The 1/10/2024 Minimum Data Set assessment dated documented the resident was cognitively intact, considered it very important to listen to music and participate in religious services, and somewhat important to go out and get fresh air.<br><br>The comprehensive care plan initiated 1/30/2024 documented personalized care would be provided, and the resident would be reminded of activities. Interventions included nursing arranged to have the resident up and ready for Catholic services and personal preferences included music and going outside.<br><br>During an interview on 4/9/2024 at 11:17 AM, Resident #40 stated there was a music activity twice a month they would have liked to attend but could not because there was not enough staff to get them out of bed. They had not been to any activities recently and they were fearful to get out of bed because they would be left in the chair and not be put back to bed after the activity was over. They stated they would also love to go outside and enjoyed flowers and gardening.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a follow up interview on 4/11/2024 at 12:22 PM, Resident #40 stated no one had asked them if they wanted to attend an activity in several months.<br><br>The April 2024 activity records documented the resident participated in 4 (in room activity) on unit activities from 4/1/2024-4/12/2024. There was no documented evidence the resident refused attendance at additional activities.<br><br>During an interview on 4/12/2024 at 12:46 PM, certified nurse aide #24 stated Resident #40 used to attend a lot of activities and enjoyed watching entertainers and going outside. It was important for residents to attend activities for socialization and go outside for fresh air instead of being cooped up indoors.<br><br>During an interview on 4/12/2024 at 1:28 PM, the Director of Activities stated activities were important for the resident's quality of life. Resident #40 refused to get out of bed and refused all out of room activities. They recently were provided with an ice cream sundae in their room. Staff might not invite them to off unit activities due to their continuous refusals. Staff should offer all residents to go to off unit activities and document refusals. They stated the resident had refused 6 activities recently and it would be important to know why the resident refused activities.<br><br>2) Resident #79 had diagnoses including limitation of activities due to disability, adjustment disorder with depressed mood, and cognitive communication deficit. The 12/23/2023 Minimum Data Set assessment documented the resident had severely impaired cognition, had verbal behaviors directed towards other 1-3 of 7 days, did not reject care, considered it important to listen to music, to be around animals, keep up with the news, to do their favorite activities, and go outside to get fresh air when the weather was good.<br><br>The 4/3/2024 comprehensive care plan documented the resident was able to make their needs known and was made aware of group activities through verbal invitation. The resident did better when staff would state it was time to go to an activity. The resident allowed individual visits, was fidgety, liked to socialize with others, and listen to music and television. Interventions included ask yes or no questions, provide fidget items as able, and transport the resident to and from activities.<br><br>During an interview on 4/9/2024 at 3:05 PM, the resident's representative stated the resident did not leave the unit to attend activities. The resident required assistance of 2 using a mechanical lift and there were not always enough staff on the unit to assist with transfers.<br><br>The resident was observed:<br><br>- On 4/10/2024 at 8:56 AM, in bed with their eyes closed and at 12:52 PM sitting in a recliner chair.<br><br>- On 4/11/2024 at 4:14 PM, in their room lying in bed in a gown.<br><br>The April 2024 activity records documented the resident participated in 6 activities on the unit and 1 activity off the unit from 4/1/2024- 4/12/2024.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/11/2024 at 4:20 PM, certified nurse aide #29 stated the resident care instructions were listed on the care plan. The care plan alerted staff to what type of activities the resident preferred. They stated Resident #79 was able to express their desire to go outside, but they typically only wanted to stay outside for a short period of time and wanted to return to the unit. The resident did not see well. They stated they put the news on the television for the resident yesterday. The resident had a fidget toy they used. Typically, the unit had 1 certified nurse aide, 1 licensed practical nurse, and 1 respiratory therapist assigned for the day.<br><br>During an interview on 4/12/2024 at 9:47 AM, certified nurse aide #30 stated the resident's care instructions were listed on the care plan. The care plan alerted staff to what type of activities the resident preferred. The ventilator (breathing machine) unit had a couple of residents that liked to go off the unit to activities. They rarely saw activities staff on the unit, and there were not a lot of 1:1 visits conducted on the unit. Resident #79 had not gone to any activities lately. The resident used a fidget toy or handheld games and enjoyed music and watching television.<br><br>During an interview on 4/12/2024 at 1:28 PM, the Director of Activities stated activities were important for the resident's quality of life. Resident #79 loved video games and had them provided but the games could not be left alone with the resident because they would disappear. The resident's family would play games with them when they visited every other day. The resident refused some activities and had recently been down to watch a movie.<br><br>10 NYCRR 415.5(f)(1)<br><br>49448 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44838<br><br>Based on observation, record review, and interview during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 1 of 3 residents (Resident #278) reviewed. Specifically, Resident #278 was admitted to the facility with congestive heart failure (the heart does not pump efficiently often causing fluid buildup) with hospital discharge orders for torsemide (diuretic, water pill) and instructions for monitoring weights; the torsemide was not ordered until 5 days after admission; and weights were not monitored as recommended.<br><br>Findings include:<br><br>The facility policy Extended Care Facility: Admission/Readmission Documentation revised 6/2023 documented the multidisciplinary team obtained information from the resident's most recent hospital records, resident and/or legal representative, transfer/discharge summary and the most recent history and physical information from the resident's attending physician upon admission to the facility. The checklist worksheet for day 1 included (but not limited to) that physician orders were entered into the electronic record and was checked by two nurses on admission orders that included a diagnosis for all medications and labs or medications that needed therapeutic level monitoring. Weights were also obtained on day 1 for admission/ readmission.<br><br>Resident #278 had diagnoses including acute (sudden onset) on chronic (long term) congestive heart failure, hypertensive heart disease (damage to the heart from high blood pressure), and diabetes. The Minimum Data Set admission assessment had not yet been completed.<br><br>The 3/29/2024 hospital discharge summary documented the resident was hospitalized [DATE]-[DATE]. The resident had a diagnosis of chronic combined heart failure, systolic and diastolic. The resident had good response to intravenous Lasix (diuretic) and had been switched back to oral torsemide. The resident weighed 229 pounds upon discharge. Discharge medications included torsemide 20 milligram tablet, take 2 tablets by mouth every day, if 3 pounds were gained in 2 days increase dose to 2 tablets twice daily for 24 hours.<br><br>The 3/29/2024 at 2:20 PM General Admission Assessment completed by Registered Nurse Unit Manager #3 documented the resident had no edema (fluid buildup). Orders were received from the admitting physician. The assessment did not include an admission weight.<br><br>The 3/29/2024 facility admission physician orders did not include torsemide or weights.<br><br>The comprehensive care plan dated 3/29/2024 documented the resident had an alteration in cardiovascular status related to arrythmia (irregular heartbeat) and congestive heart failure. Approaches included to monitor and report any edema and changes in weight, monitor and report any changes in lung sounds, and monitor and report any chest pain or shortness of breath.<br><br>The resident's 3/30/2024 weight record documented a weight of 216.0 pounds.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A 4/2/2024 physician order documented torsemide oral tablet 20 milligrams, give 2 tablets by mouth one time a day for congestive heart failure, with a start date of 4/3/2024.<br><br>The 4/2024 Medication Administration Record documented torsemide oral tablet 20 milligrams, give 2 tablets by mouth one time a day for congestive heart failure with a start date as 4/3/2024. The medication was documented as administered at 9:00 AM from 4/3/2024-4/12/2024.<br><br>During an interview on 4/9/2024 at 11:04 AM, Resident #278 stated they were worried that on admission they did not receive their diuretics for the first few days. They stated they had taken torsemide and weighed themself daily at home but had only been weighed once since the day they were admitted . They stated they were receiving their diuretic now but was still not being weighed daily.<br><br>The resident's weight record documented weights on 4/9/2024 of 219.5 pounds and on 4/11/2024 of 220.5 pounds.<br><br>A 4/12/2024 physician order documented daily weights in the morning for edema.<br><br>During an interview on 4/12/2024 at 10:38 AM, registered nurse Supervisor #13 stated new admission medications were entered into the electronic health record by a registered nurse. A second check was done by another registered nurse, before a verbal approval by the medical provider. Reconciliation was done from the hospital discharge summary, compared with home medications, and then entered into the electronic health record. Any registered nurse could do the transcribing of orders, activation was done by the registered nurse with medical approval after the orders were checked at least twice.<br><br>During an interview on 4/12/2024 at 11:59 AM, Assistant Director of Nursing #4 stated new admission orders were obtained from the hospital discharge packet. A registered nurse would put the orders in the computer, and then a second registered nurse would check them. The orders would then show as active, and the medical provider would sign off. The orders for Resident # 278 were entered by Registered Nurse Unit Manager #3, and a second check was done by registered nurse #32. The Assistant Director of Nursing was not aware of any problem with Resident #278's torsemide on admission. There was an admission checklist used, but it was not kept after the admission was completed. If there was an order that was not clear, the medical provider should have been called for clarification. An order for a diuretic for a resident with congestive heart failure would be very important for their health.<br><br>During an interview on 4/12/2024 at 3:00 PM, Registered Nurse Unit Manager #3 stated medications for new admissions were entered into the electronic health record by a registered nurse, with a 2nd check by another registered nurse, then signed by the medical provider. If an order was not clear they would call medical for clarification as soon as possible. When transcribing orders, they reviewed medical history and discharge orders from where the resident was coming from. The danger of not receiving a diuretic that was on the discharge orders was increased edema, shortness of breath, or further exacerbation of congestive heart failure. They did not remember entering admission medications for Resident #278 and was not aware the resident did not receive torsemide upon admission.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/12/2024 at 4:35 PM, physician #33 stated they counted on the nurses for reconciling medications from the hospital discharge summary. They would then review and approve the medications in the electronic health record. If torsemide was recommended on the hospital discharge with weight parameters, they would have expected the medication to be ordered as well as daily weights. If a resident with congestive heart failure did not receive the proper diuretics, they have increased edema, shortness of breath, and possibly re-hospitalization due to those symptoms.<br><br>During an interview on 4/12/2024 at 5:55 PM, registered nurse #32 stated medication orders for a new admission were put in the computer by a nurse with a 2nd nurse check. Medical would then approve the orders. The medical providers depended on nursing for entering medication orders by using the hospital discharge summary and home medication lists. They did not remember if they reconciled Resident #278's medications when they were admitted . They did remember hearing there was a problem with the torsemide. It had been on the home medication list and discharge summary but was missed. Adverse effects might have been edema or shortness of breath. They used an admission check list, and it should have been caught. The 2nd nurse check should have also caught the error.<br><br>10NYCRR415.12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335427 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/12/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oneida Health Rehabilitation and Extended Care | 323 Genesee Street<br>Oneida, NY 13421 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49448<br><br>Based on observation, record review, and interview during the recertification and abbreviated (NY00336433) surveys conducted 4/9/2024-4/12/2024, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new pressure ulcers from developing for 1 of 3 residents (Resident #119) reviewed. Specifically, Resident #119 developed facility acquired pressure ulcers and had a physician order for a specialty mattress (a powered pressure reducing air mattress). There was no documented evidence the mattress was checked for function for 14 days after it was ordered, and the mattress was observed not connected to the pump and the pump was not operational.<br><br>Findings include:<br><br>The facility policy Prevention and Treatment of Pressure Ulcer revised 12/2020, documented the facility ensured residents that developed pressure ulcers received the necessary treatment and services to promote healing and/ or prevent infection. The registered nurse or the supervisor, initiated skin protocols and obtained physician orders. Standards included treatments were completed as ordered and the need for an anti-pressure mattress was assessed. Treatments were documented in the electronic medical record.<br><br>Resident #119 had diagnoses including left femur (hip) fracture, facility acquired Stage 2 pressure ulcer (partial thickness loss of skin presenting as a shallow crater) on the back, and facility acquired Stage 2 pressure ulcer of sacral region (end of spine/ buttocks). The Minimum Data Set assessment dated [DATE] documented the resident was cognitively intact, was dependent for bed mobility and transfers, had pressure ulcers that were not present on admission, received daily pressure ulcer care, application of ointments/ medications other than to feet, and had pressure reducing devices for the bed and chair.<br><br>The 2/16/2024 admission assessment by registered nurse Supervisor/Staff Development Coordinator #13 documented the resident had a surgical incision to the left hip and dry skin to bilateral heels.<br><br>The comprehensive care plan initiated on 2/16/2024 and revised on 2/21/2024 documented the resident had suspected deep tissue injury (purple or maroon discoloration due to damage to underlying tissue) to bilateral heels related to recent hip surgery and weakness. The areas would be followed by the skin team weekly. Approaches included turning and repositioning every 2 hours, treatment per physician order, and pressure relieving boots per physician order.<br><br>The 2/16/2024 Braden Score Assessment (a tool for assessing risk of development of pressure ulcers) by registered nurse Supervisor/ Staff Development Coordinator #13 documented the resident was at risk for pressure ulcers.<br><br>The 2/18/2024 Physician orders documented Juven oral packet, mix with 240 milliliters liquid twice a day for wound healing.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 2/21/2024 weekly skin check by licensed practical nurse #8 and the 3/20/2024 weekly skin check by licensed practical nurse #7 documented the resident had open areas, red marks, rashes, or bruises. Details were not documented.<br><br>Skin/Wound progress notes dated 2/21/2024 and 2/28/2024 by Assistant Director of Nursing #4 documented the bilateral heel deep tissue injuries were assessed and measured during weekly wound rounds. The bilateral heels measured 5 centimeters by 5 centimeters by 0 centimeters on first assessment. The physician was notified and an order for skin prep (protectant) to bilateral heels was obtained. The resident had pressure relieving boots in place although the resident frequently refused the boots. The resident also had an abductor pillow for use while in bed but frequently refused its use as it was uncomfortable.<br><br>The 3/1/2024 physician #5 progress note documented the resident had lower back discomfort, had Stage 2 pressure ulcers to the lower back and sacral area and the plan was for dressing changes, air mattress, and off-loading.<br><br>The 3/6/2024 physician #6 telephone order documented the resident was to have an air mattress set per weight and check function every shift.<br><br>The 3/6/2024 Skin/Wound progress note by Assistant Director of Nursing #4 documented the resident had small pillows under their heels and was told this added more pressure and was advised to wear the pressure relieving boots. The heels were assessed, and the right heel deep tissue injury measured 2.5 centimeters x 3 centimeters x 0 centimeters, the left heel deep tissue injury measured 3 centimeters x 3 centimeters x 0 centimeters. There was no documented evidence a specialty mattress was recommended or ordered.<br><br>The 3/13/2024 and 3/20/2024 Skin/Wound progress notes by Assistant Director of Nursing #4 documented he bilateral heel deep tissue injuries were assessed and measured. The wound measurements were without significant change.<br><br>The March 2024 Treatment Administration Record documented specialty air mattress, settings per weight, and check function every shift with a start date of 3/6/2024. There was no documented evidence the mattress was checked for functioning every shift as ordered from 3/6/2024 through 3/20/2024.<br><br>A 3/20/2024 nursing progress note by Assistant Director of Nursing #4 documented an unidentified licensed practical nurse requested an assessment as the resident had wounds to their buttocks. Four new wounds were identified and included an unstageable ulcer to the coccyx (end of tailbone) measuring 1.5 centimeters x 1.5 centimeters x 0.1 centimeters with yellow slough (dead tissue) covering 100% of the wound bed; an unstageable ulcer to the left buttocks measuring 1.5 centimeters x 0.5 centimeters x 0.1 centimeters with slough covering 100% of the wound bed; an unstageable wound to the right buttocks measuring 1.5 centimeters x 1 centimeter x 0.1 centimeters with slough covering 100% of the wound bed; and an unstageable wound to left upper buttocks measuring 0.5 centimeters x 0.2 centimeters x 0.1 centimeters with slough covering 100% of the wound bed. The physician was notified and orders for wound dressings included debriding ointment (used to remove dead tissue) to all wounds, cover with gauze, and dry sterile dressing. The resident was currently on an alternating air mattress and did not want to shift weight off their buttocks. The resident was advised staff would continue to attempt repositioning.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Skin/Wound progress notes by Assistant Director of Nursing #4 documented:<br><br>- on 4/3/2024 the suspected deep tissue injury to the right heel measured 2.5 centimeters x 3 centimeters x 0 centimeters. The suspected deep tissue injury to the left heel measured 3.5 centimeters x 4 centimeters x 0 centimeters. The unstageable pressure ulcer to the coccyx measured 1.5 centimeters x 1.5 centimeters x 0.1 centimeters. The unstageable pressure ulcer to the right buttocks measured 1 centimeter x 1 centimeter x 0. 1 centimeters. The unstageable pressure ulcer to the left buttocks measured 5 centimeters x 5.5 centimeters x 0.3 centimeters.<br><br>- on 4/10/2024 the suspected deep tissue injury to the right heel measured 2.5 centimeters x 3.5 centimeters x 0 centimeters. The right heel wound now had drying edges of wound lifting revealing pink skin underneath. The suspected deep tissue injury to the left heel measured 3.5 centimeters x 4 centimeters x 0 centimeters. The left heel wound was drying. The Stage 2 pressure ulcer to the coccyx measured 1.5 centimeters x 1 centimeter x 0.1 centimeters. The coccyx wound was previously unstageable with slough covering wound bed, now Stage 2 with 100 percent granulation (pink, new tissue) tissue. The Stage 2 pressure ulcer to the right buttocks measured 0.5 centimeters x 0.5 centimeters x 0.1 centimeters. The right buttocks wound was previously unstageable with slough covering the wound bed. The wound bed was now visible with 100% granulation tissue. The unstageable pressure ulcer to the left buttocks measured 5 centimeters x 5 centimeters x 0.3 centimeters. The left buttocks wound had dark slough covering the entire wound bed and remained unstageable.<br><br>The following observations were made:<br><br>- on 4/9/2024 at 10:32 AM, in the resident's room there was an air mattress device pump on the floor under the resident's bed, the pump was not on, and the pump device was cracked. At 2:31 PM, the resident was lying in bed, the pump device was not on, the control was set for weight of 225 pounds, the cracked pump device was in between the foot of mattress and the foot of bed frame, and the tubing from the pump device to the air mattress was not connected. The mattress was fully inflated.<br><br>- on 4/10/2024 at 8:58 AM and 3:38 PM, the resident was lying in bed, the air mattress pump device was not on, the tubing from pump device to air mattress was not connected, and the cracked pump device was in between the foot of the mattress and the foot of bed frame. The mattress was fully inflated.<br><br>- on 4/11/2024 at 10:02 AM and 1:26 PM, the resident was lying in bed, the air mattress pump device was not on, the tubing from the pump device to the air mattress was not connected, and the cracked pump device was in between the foot of the mattress and the foot of bed frame. The mattress was fully inflated.<br><br>The April 2024 Treatment Administration Record documented the air mattress function was checked:<br><br>- on 4/9/2024 day shift by licensed practical nurse #11; and evening and night shift by licensed practical nurse #10.<br><br>- on 4/10/2024 day shift by licensed practical nurse #9; evening and night shift by licensed practical nurse #10.<br><br>- on 4/11/2024 day shift by licensed practical nurse #8<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a dressing change observation on 4/11/2024 at 1:39 PM with licensed practical nurse #8 the left buttocks wound was approximately the size of a billiard ball with serosanguinous (blood tinged fluid) drainage. The wound bed had yellow tissue with dark slough. There were two small wounds approximately the size of a pencil eraser with pink wound beds on the left and right buttocks. Licensed practical nurse #8 stated the wounds were improving and interventions included the resident was turned and positioned every 2 hours. They stated Resident #119 was on a regular mattress and if they were on an air mattress there would be an air mattress machine and there was not. There were air mattress cords on the floor that were attached to the mattress, but an air mattress must not have ever been hooked up. Resident #119 was at risk for pressure ulcers and if they had an air mattress ordered it should be on and in use. If they had an order, it would be signed off on the Treatment Administration Record. If it was signed off on the Treatment Administration Record, it meant that it was verified as on and working. If the mattress was not on it could make the pressure ulcers worse. They did not remember the resident having an air mattress despite them documenting on the Treatment Administration Record the mattress function was checked on 3/22/2024, 3/30/2024, 4/4/2024, 4/5/2024, and 4/8/2024.<br><br>During an interview on 4/12/2024 at 1:45 PM, the Director of Plant Operations stated that broken air mattresses would be discarded and replaced with a new air mattress. They stated the device would be checked for electrical safety upon being brought into the facility. The Director of Plant Operations stated the biomedical department was not aware of the broken air mattress and did not have any work orders prior to the observation on 4/11/2024. They verified that the electrical pump for the mattress was broken.<br><br>During an interview on 4/12/2024 at 2:03 PM Assistant Director of Nursing#4 stated they assessed all pressure wounds in the facility weekly. They made recommendations and obtained physician orders. If they recommended and received an order for an air mattress it would be entered in the Treatment Administration Record. The air mattress was checked every shift and documentation meant it was checked that it was on and functioning. Air mattresses were important to reduce pressure and if an air mattress was not on or not functioning properly wounds could get worse or they could develop new wounds. Resident #119 was at risk for pressure and had currently had 5 facility acquired pressure sores. The areas on the bilateral heels were discovered on 2/21/2024 and the 3 wounds to the back/ sacral area were discovered on 3/20/2024. Some of the wounds were healing and the large left buttocks wound was slightly smaller, but the wound bed was not getting better. Resident #119 had orders for an air mattress and pressure relieving boots but frequently refused the boots. If staff had determined the machine was not functioning properly, they should have put a ticket in with biomedical to have the unit repaired or a new system installed. They had done a wound assessment on 4/10/2024 but did not check the air mattress or the pump device as they normally did. They were made aware of the broken air mattress device for the resident yesterday afternoon after the dressing change observation.<br><br>During an interview on 4/12/2024 at 5:41 PM physician #6 stated if an air mattress was ordered, they expected that it was used as it was medically indicated. Air mattresses were indicated for residents with pressure ulcer or at risk for pressure sores. If an air mattress was ordered but was not in place, they expected to be notified to order alternate therapies if an air mattress was not available. They expected their orders to be followed. An air mattress would only be useful if it was functioning properly and if it was not, it should have been addressed immediately as this could make the pressure ulcers worse. They could not recall if they had provided a telephone order for an air mattress for Resident #119. They sometimes had telephone orders in the computer they did not remember giving. They did not normally care for this resident unless they were on call.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10NYCRR 415.12(c)(1) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>44838<br><br>Based on observation, record review, and interview during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 of 2 residents (Resident #278) reviewed. Specifically, Resident #278 received continuous positive airway pressure therapy (a machine used to keep the airway open by delivering continuous air through the nose and mouth) without a plan to regularly clean the machine to prevent contaminations.<br><br>Findings included:<br><br>The facility policy Noninvasive Ventilation BiPAP (bilevel positive airway pressure) /CPAP (continuous positive airway pressure) last revised 10/2021 documented noninvasive ventilation was a means of delivering ventilation support through a noninvasive interface rather than an invasive artificial airway. Setup, maintenance, and monitoring was the responsibility of the respiratory therapist. An indication for use was sleep apnea (breathing repeatedly stops and starts during sleep) /nocturnal hypoventilation (breathing too shallow or slow during sleep).<br><br>Manufacturer's recommendations for maintenance of continuous positive airway pressure equipment were for daily cleaning of the mask cushion and the humidifier tub (reservoir for placing water), and weekly cleaning of the tubing.<br><br>Resident #278 had diagnoses including acute on chronic congestive heart failure, hypertensive heart disease, and sleep apnea. The Minimum Data Set admission assessment had not yet been completed.<br><br>The 3/29/2024 physician order documented continuous positive airway pressure at night use resident home settings in the evening for sleep apnea. There were no documented orders for cleaning and maintaining the machine.<br><br>The comprehensive care plan dated 3/29/2024 documented continuous positive airway pressure therapy for obstructive sleep apnea, encourage resident use of therapy, and maintain same settings as at home. Assist resident with applying continuous positive airway pressure therapy. The care plan did not include cleaning/disinfecting instructions.<br><br>Resident care information (Kardex) included encourage use of continuous positive airway pressure therapy. The care information did not include cleaning/disinfecting instructions.<br><br>The April 2024 electronic medication administration record documented continuous positive airway pressure at night use resident home settings in the evening for sleep apnea with a start date of 3/29/2024. The therapy was signed as administered 4/1/2024-4/11/2024. The electronic medication or treatment administration records did not include directions for cleaning/disinfecting the continuous positive airway pressure machine components (tubing, mask, or humidifier reservoir).<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/9/2024 at 4:00 PM, Resident # 278 stated they were concerned that staff were not cleaning their continuous positive airway pressure equipment. They had asked for it to be cleaned and at least be hung to dry to prevent mold and bacteria from getting into their lungs. So far nobody had assisted them with cleaning of the unit.<br><br>During an interview on 4/12/2024 at 10:38 AM, Registered Nurse Supervisor #13 stated continuous positive airway pressure therapy should have orders for use and settings. Only sterile water should be used for humidification. The reservoir, mask, and tubing should be cleaned daily by nursing and should be on the treatment administration record for completion.<br><br>During an interview on 4/12/2024 at 11:05 AM, licensed practical nurse #16 stated care information was found in the care plan. Continuous positive airway pressure therapy required orders and the machine should be cleaned daily. Cleaning instructions should be in the electronic treatment administration record. Resident #278 did not have cleaning instructions in the treatment record. If the equipment was not cleaned properly, bacteria could build up and possibly cause infection.<br><br>During an interview on 4/12/2024 at 2:53 PM, respiratory therapist #18 stated their main duties were on the ventilator unit. They assisted with continuous positive airway pressure therapy if needed. Continuous positive airway pressure therapy required orders for use. Continuous positive airway pressure therapy tubing and masks should be cleaned to prevent respiratory infections. If there was moisture present in the tubing or mask bacteria could breed and cause infections.<br><br>During an interview on 4/12/2024 at 3:00 PM, Registered Nurse Unit Manager #3 stated medications and treatments for new admissions were entered into the electronic health record by a registered nurse, then approved by a medical provider. If continuous positive airway pressure therapy was ordered, cleaning should be put on the treatment administration record for nursing to complete.<br><br>10 NYCRR 415.12(k)(6) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>44838<br><br>48675<br><br>Based on observation, record review, and interviews during the recertification survey conducted 4/9/2024-4/12/2024 the facility did not ensure sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for 12 of 12 anonymous residents. Specifically, during a confidential resident group meeting residents stated their call bells were not answered timely and meals were not hot when served due to the lack of staff. Additionally, deficiencies related to staffing levels were identified in the areas Activities of Daily Living (F 677), Food Palatability (F804), and Activities (F 679).<br><br>Finding include:<br><br>The facility policy Nursing Service Staffing Schedule revised 6/2021 documented the facility would provide a working schedule for each member of nursing services that would meet staff needs and the needs of all the patient care units. The Nurse Managers were responsible for coordinating with shift supervisors regarding the scheduling of nursing personnel, collaborating with the supervisors regarding transfers and replacements, and reviewing the daily needs and developing staffing patterns. The supervisors were responsible for assigning the float nurses from the nursing office and reassigning staff as needed to meet patient needs.<br><br>The Facility Assessment, last updated 12/26/2023, documented the facility was licensed for a total of 160 skilled nursing bed. There were 149 residential health care facility (RHCF) beds and 11 ventilator (breathing machine) beds. Most residents required assistance with mobility, bathing, dressing, toileting and transferring. The facility's staffing plan was based on resident population and their needs for care. The staff plan included the following positions with the desired number total for the facility, by shift: certified nurse aides, desired number for day shift 20; evening shift 16; and night shift 8. Licensed practical nurses, desired number for day shift 8; evening shift 8; and night shift 4. Registered nurses, desired number for day shift 4; evening shift 4; and night shift 4.<br><br>During the entrance conference interview on 4/9/2024 at 9:50 AM the Administrator stated the facility census was 130 residents.<br><br>Scheduled Staffing: The facility staffing schedule provided on day 1 of survey documented the following nursing schedule for 4/9/2024 through 4/12/2024 (there were 4 nursing care units: Units 2, 3, 4, and 5 which included the 11 ventilator beds):<br><br>Tuesday 4/9/2024, day shift staffing documented the following schedule for 130 residents: - 3 registered nurses. - 6 licensed practical nurses. - 12 certified nurse aides (1 worked 6:00 AM- 10:00 AM)<br><br>Tuesday 4/9/2024, evening shift staffing documented the following schedule for 130 residents: - 1 registered nurse. - 5 licensed practical nurses. - 10 certified nurse aides.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Tuesday 4/9/2024, night shift staffing documented the following schedule for 130 residents: - 1 registered nurse. - 5 licensed practical nurses. - 9 certified nurse aides (1 worked 3:00 AM- 6:00 AM).<br><br>Actual staffing documented:<br><br>Tuesday 4/9/2024, day shift staffing:<br><br>- Unit 2: registered nurse supervisor (covering all units), 1 licensed practical nurse, 1 certified nurse aide for 15 residents. - Unit 3: 1 registered nurse manager, 1 licensed practical nurse, and 4 certified nurse aides for 40 residents. - Unit 4: 2 licensed practical nurses, 3 certified nurse aides for 37 residents. - Unit 5: 1 registered nurse manager, 2 licensed practical nurses, 4 certified nurse aides (1 worked 6:00 AM- 10:00 AM) for 38 residents.<br><br>Tuesday 4/9/2024, evening shift staffing: - Unit 2: 1 registered nurse supervisor (covering all units), 1 licensed practical nurse, 2 certified nurse aides (1 worked 7:00 PM- 10:00 PM) for 15 residents. - Unit 3: 1 licensed practical nurse, 4 certified nurse aides (1 worked until 6:00 PM) for 40 residents. - Unit 4: 1 licensed practical nurse, 3 certified nurse aides for 37 residents. - Unit 5: 2 licensed practical nurses, 3 certified nurse aides for 38 residents.<br><br>Tuesday 4/9/2024, night shift staffing: - Unit 2: 1 registered nurse supervisor (covering all units), 1 licensed practical nurse, 1 certified nurse aide for 15 residents. - Unit 3: 1 licensed practical nurse, 2 certified nurse aides for 40 residents. - Unit 4: 1 licensed practical nurse, 2 certified nurse aides for 37 residents. - Unit 5: 2 licensed practical nurses, 3 certified nurse aides for 38 residents.<br><br>Scheduled Staffing:<br><br>Wednesday 4/10/2024, day shift staffing documented the following schedule for 130 residents: - 3 registered nurses (1 worked 11:00 AM- 3:00 PM). - 6 licensed practical nurses. - 15 certified nurse aides.<br><br>Actual staffing documented:<br><br>Wednesday 4/10/2024, day shift staffing: - Unit 2: 1 registered nurse supervisor (covering all units), 1 licensed practical nurse, 1 certified nurse aide, 1 unit helper. - Unit 3: 1 registered nurse manager, 1 licensed practical nurse, 5 certified nurse aides. - Unit 5: 1 registered unit manager, 2 licensed practical nurses, 5 certified nurse aides.<br><br>Scheduled Staffing:<br><br>Thursday 4/11/2024, day shift staffing documented the following schedule for 130 residents: - 3 registered nurses. - 7 licensed practical nurses. - 15 certified nurse aides.<br><br>Actual staffing documented:<br><br>Thursday 4/11/2024, day shift staffing:<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Unit 2: 1 licensed practical nurse, 1 certified nurse aide, 1 unit helper. - Unit 3: 1 registered nurse manager, 1 licensed practical nurse, 5 certified nurse aides, 1 unit helper. - Unit 5: 1 registered nurse manager, 3 licensed practical nurses, 4 certified nurse aides.<br><br>Activities of Daily Living (refer to F 677)<br><br>Resident #40 was not assisted out of bed for toileting, and Resident #58 was not assisted with toileting every 2 hours as care planned.<br><br>During an observation and interview on 4/9/2024 at 11:17 AM, Resident #40 was in bed and stated they would like to get out of bed a couple of times a week, but it took assistance of 2 and there was not enough staff, so they did not get out of bed. They stated the staff did not let them go to the bathroom because they fell approximately 6 months ago in the bathroom and now, they would use an incontinence brief in the bed when they needed to go to the bathroom and then ring the call bell for staff to come and change them. They stated they knew when they needed to urinate and would often ask for a bedpan to defecate in although they stated they would have preferred to get up and go to the bathroom.<br><br>During an observation and interview on 4/11/2024 at 4:48 PM, Resident #40's call light was on. Their call light was answered at 5:11 PM. They stated they needed their incontinence brief changed after they urinated and stated that was a short call bell response time.<br><br>Food Palatability (refer to F 804)<br><br>Food was not served at appetizing temperatures during lunch meals on 4/12/2024.<br><br>During a resident meeting with 12 anonymous residents on 4/9/2024 at 1:35 PM, they stated the meal carts would arrive to the unit, but there was not enough staff to pass the meal trays timely.<br><br>During an interview on 4/12/2024 at 10:51 AM, certified nurse aide #14 stated unit staff passed the meal trays as quickly as they could, but it depended on the number of staff that were on the unit how quickly the meal trays were passed. The meal carts were not separated where the residents ate their meals.<br><br>Activities (refer to F 679)<br><br>Resident #79 was not provided meaningful activities that met their interests and preferences.<br><br>During an interview on 4/12/24 at 9:47 AM, certified nurse aide #30 stated they worked on unit 5 and the ventilator unit. Some residents liked to go to activities, they rarely saw activities on the unit, and they did not see a lot of 1:1 room visits. Resident #79 had not gone to any recent activities, therapy would occasionally take them off the unit, and they liked to use fidget toys, handheld games, and their preferences were TV and music. They stated 10 of 11 residents required assistance of 2 for care, 2 certified nurse aides were usually scheduled to work on the unit, but there was usually only 1 nurse, 1 certified nurse aide and 1 respiratory therapist working which could have caused extended wait times for Resident #79 to get up.<br><br>General Staffing<br><br>(continued on next page) |

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| | 335427 | A. Building<br>B. Wing | 04/12/2024 |

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

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/11/24 at 4:20 PM, certified nurse aide #29 stated Resident #102 required assistance of 2 or more due to limited range of motion and sometimes needed assistance of 3. The lack of staff could have led to the resident having to wait to use the bed pan, get transferred, repositioned, or receive incontinence care. When there was 1 certified nurse aide, 1 nurse, and 1 respiratory therapist on the unit it made it difficult to provide care timely.<br><br>During an interview on 4/12/2024 at 5:00 PM, the Administrator stated resident care needs were included when they determined staffing levels on each unit. Staff retention was being monitored and reported to Senior Management. They had identified the biggest turnover was certified nurse aides that stayed for less than 1 year. They were developing a strategy to change that. They had recent job fairs and were able to recruit nurses and certified nurse aides. Their biggest staffing factor was having 5 nurses out on medical leave since December 2023. They had been filling the staffing gap with agency staff, management had to sometimes step in, and they had to sometimes pull staff from other units. They were unsure if the resident's wait time was increased due to staffing. They stated last October pay rates were raised and they were looking at raising rates again, offering a night shift sign on bonus, and they were working with Human Resources to streamline the onboarding process.<br><br>10 NYCRR 415.13(a)(1)(i-iii)<br><br>49448 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>44838<br><br>49448<br><br>Based on observation, record review, and interviews during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not ensure that residents were free of any significant medication errors for 2 of 5 residents (Residents #44 and #118) reviewed. Specifically, Resident #118 did not receive sacubitril-valsartan (used to treat heart failure) as ordered; and Resident #44 did not receive brimonidine tartrate (used to treat glaucoma) eye drops, ammonium lactate (used to treat dry skin) lotion, docusate sodium (stool softener), and Juven (a protein supplement) as ordered.<br><br>Findings include:<br><br>The facility policy Medication Transcription and Administration reviewed 10/19/2020 documented medications were provided to patients accurately and safely. It assured a standard method that medications were transcribed and administered safely and reduced the potential of error. The process for medication administration included medications were opened just prior to administration and the medications were compared to the medication administration record when opened. The licensed professional remained with the patient until all the medications were given.<br><br>The undated facility Medication Pass Times documented once daily medications were given between 8:00 AM and 12:00 PM and twice daily medications were given between 8:00 AM and 12:00 PM and 8:00 PM and 10:00 PM (twice daily diuretics were administered at 8:00 AM and 4:00 PM).<br><br>1)Resident #118 was admitted to the facility with diagnoses including acute systolic (pressure in the arteries when the heart beats) heart failure, hypertension (high blood pressure), and cardiomyopathy (disease of the heart muscle). The 2/21/2024 Minimum Data Set assessment documented the resident was cognitively intact, had debility, cardiorespiratory conditions, and took medications for their medical conditions.<br><br>A 2/14/2024 physician order documented sacubitril-valsartan (brand name Entresto) 24-26 milligram tablet; give 1 tablet by mouth twice daily for hypertension.<br><br>During a medication pass observation on 4/11/2024 at 9:22 AM with licensed practical nurse #8, the following medications were administered to Resident #118:<br><br>- One finasteride 5 milligram tablet.<br><br>- One metoprolol succinate extended release 25 milligram tablet.<br><br>- Miralax 17 grams mixed with water.<br><br>- One potassium chloride extended release 20 milliequivalents tablet.<br><br>- Two tamsulosin hydrochloride 0.4 milligram capsules.<br><br>(continued on next page) |

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

- One apixaban 2.5 milligram tablet.

- Three gabapentin 100 milligram capsules.

The sacubitril-valsartan was not administered.

The April 2024 Medication Administration Record documented sacubitril-valsartan oral tablet 24-26 milligram, give 1 tablet by mouth two times a day for hypertension daily and evenings. On 4/11/2024 sacubitril-valsartan was signed as administered by licensed practical nurse #8 for the daily dose.

During an interview on 4/11/2024 at 9:34 AM licensed practical nurse #8 stated they did not see sacubitril-valsartan on the medication administration record, and they disposed of the medication. During a follow-up interview on 4/11/2024 (undocumented time), licensed practical nurse #8 stated the sacubitril-valsartan was discontinued, and they notified the pharmacy.

There was no documented evidence the sacubitril-valsartan was discontinued, or the pharmacy had been notified.

Attempts were made for a follow-up telephone interview with licensed practical nurse #8 on 4/12/2024 at 12:00 PM, 1:14 PM and 3:41 PM. The Administrator also attempted to contact the nurse. There was no return phone call from licensed practical nurse #8.

2) Resident #44 was admitted to the facility with diagnoses including glaucoma (eye disease), chronic non-pressure ulcers to bilateral lower extremities, and Stage 3 pressure ulcers (full thickness tissue loss). The 1/23/2024 Minimum Data Set assessment documented the resident was cognitively intact, had medically complex conditions, and took medications for their medical conditions.

Physician orders documented:

- on 1/16/2024 ammonium lactate (used to treat dry skin) external cream 12 percent; apply to bilateral legs topically twice daily for skin irritation.

- on 1/16/2024 brimonidine tartrate (used to treat glaucoma) ophthalmic solution 0.2 percent; 1 drop in right eye twice daily for glaucoma.

- on 3/16/2024 Juven (nutritional supplement) oral packet; 1 unit by mouth twice daily for pressure ulcers.

- on 3/21/2024 docusate sodium capsule 100 milligrams give 1 capsule by mouth two times a day for constipation.

During a medication pass observation on 4/11/2024 at 9:22 AM with licensed practical nurse #8, the following medications were administered to Resident #44:

- Aldactone (antihypertensive) 25 milligram tablet.

- GlycoLax Powder (laxative) 17 grams mixed with fluids.

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - potassium chloride (mineral supplement) extended-release 20 milliequivalents tablets.<br><br>- Advair diskus inhalation aerosol powder breath activated 100-50 microgram per actuation.<br><br>- ferrous sulfate (mineral supplement) 325 milligram tablet.<br><br>- metoprolol tartrate (antihypertensive) 25 milligram tablet.<br><br>- pregabalin (pain reliever) 50 milligram capsule.<br><br>- ursodiol (treats gall stones) 300 milligram capsule.<br><br>Ammonium lactate cream, brimonidine tartrate eye drops, docusate sodium, and Juven were not administered.<br><br>The April 2024 Medication Administration Record documented the following scheduled morning medications were signed as administered by licensed practical nurse #8 on 4/11/2024:<br><br>- ammonium lactate external cream 12%, apply to both legs topically for skin irritation.<br><br>- brimonidine tartrate ophthalmic solution 0.2%, instill<br><br>- One docusate sodium 100 milligram capsule.<br><br>- One Juven oral packet.<br><br>Attempts were made for a follow-up telephone interview with licensed practical nurse #8 on 4/12/2024 at 12:00 PM, 1:14 PM and 3:41 PM. The Administrator also attempted to contact the nurse. There was no return phone call from licensed practical nurse #8.<br><br>During an interview on 4/12/2024 at 2:03 PM, Assistant Director of Nursing #4 stated staff should be following medication orders. If a medication was signed off as administered on the Medication Administration Record, it meant that it was witnessed as being taken. If a medication was not given there were other administration documentation options such as refused, held due to parameters, out of the building, or hospitalized . It was important that residents' medications were administered as ordered to treat their medical conditions. If medications were not given as ordered, residents could have an adverse reactions such as hyperglycemia (high blood sugar), hypoglycemia (low blood sugar), fluid retention, or shortness of breath. If there was a pattern of a resident not receiving their medications for whatever reason, they expected the physician to be notified.<br><br>During an interview on 4/12/2024 at 3:25 PM, physician #5 stated they expected their medical orders to be followed. Residents received medications to address medical problems, the medication orders were part of the treatment plan, and they were expected to be followed. They cared for Resident #44 and was not made aware the resident did not receive ammonium lactate lotion, brimonidine tartrate eye drops, docusate sodium, and the Juven packet as ordered. The resident should have received those medications. Without the medications, Resident #44 could have negative effects including worsening glaucoma, worsening wounds, and issues with their dry skin. Resident #118 could have filled up with fluid. They expected to be notified if medications were not given as ordered.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10NYCRR 415.12(m)(2) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>44838<br><br>Based on observation, interview, and record review during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not assist residents in obtaining routine and emergency dental care for 1 of 1 (Resident #102) resident reviewed. Specifically, the facility did not obtain dental services for Resident #102 when they complained of tooth pain and concerns about tooth decay.<br><br>Findings include:<br><br>The undated facility policy Dental Care documented the dental services provided consisted of but were not limited to a complete oral examination of each resident by a licensed and currently registered dentist or dental hygienist within fourteen (14) days of admission. Emergency dental care was provided by the contracted dentist or arrangements would be made to obtain dental care from the dentist as designated upon admission.<br><br>Resident #102 had diagnoses including complete quadriplegia (paralysis of all 4 limbs), acute and chronic respiratory failure, and ventilator (breathing machine) dependence. The 1/23/2024 Minimum Data Set documented the resident had intact cognition, was dependent for all activities of daily living, and had no obvious or likely cavities or broken teeth, or mouth pain.<br><br>The 12/20/2023 Nursing General Admission assessment completed by Registered Nurse Unit Manager #3 documented the resident's mouth was pink without additional concerns.<br><br>The comprehensive care plan revised 12/28/2023 documented the resident had an activity of daily living self-care deficit related to immobility, cervical (neck) fracture, and ventilator dependence. The resident was dependent for oral hygiene. There was no comprehensive care plan that outlined problems, goals and approaches that addressed oral health concerns specific to the resident.<br><br>During an interview on 4/09/2024 at 1:00 PM, the resident stated they had not seen a dentist since their admission (12/2023). They were concerned they had a tooth that felt like it may be decayed. The resident was worried that bacteria from their mouth could get into their respiratory tract, and due to their already compromised respiratory status this could be very dangerous. They said they had told a nurse about the sore tooth but was not sure which nurse.<br><br>Nursing progress notes from 3/1/2024-4/12/2024 did not include documentation of dental concerns voiced by the resident.<br><br>There was no documented evidence of a dental consult in the resident's medical record.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/12/2024 at 3:29 PM, Registered Nurse Unit Manager #3 stated residents were not seen by a dentist on admission. It was only recommended if a resident was having dental issues. They were aware Resident #102 was complaining of tooth pain. They stated the vent unit nurse had told them about the resident having tooth pain and thought that nurse had notified medical of the need for attention. They could not find a progress note written regarding the tooth pain or need for a dental consult. Dental care should be provided to maintain oral health. The risk of bacteria traveling from the mouth to the respiratory tract could cause infection. For a resident with chronic respiratory failure that could be especially dangerous.<br><br>During an interview on 4/12/2024 at 3:35 PM, Assistant Director of Nursing #4 stated a dentist came to the facility every Wednesday. All residents should have a dental consult ordered on admission. Dental consults should be ordered by the nurse that entered admission orders for medical approval. Resident #102 had no dental consult ordered and had not been seen by the dentist. Dental care was important to maintain oral health and prevent decay. A resident who had respiratory compromise would be at increased risk of bacteria spreading from the mouth and causing infection. They were not sure a dental consult was not ordered on admission. It should have been caught on the admission checklist.<br><br>10NYCRR 415.17(b) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>27522<br><br>Based on observation and interview during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not ensure each resident received and the facility provided food and drink that was palatable, flavorful, and at an appetizing temperature for 1 of 2 meals reviewed (4/12/2024 lunch meal). Specifically, food was not flavorful and was not served at palatable and appetizing temperatures during the lunch meal on 4/12/2024.<br><br>Findings include:<br><br>The facility policy Food Holding Temperature Requirements revised 5/2023 documented food temperatures were taken prior to service and ensured that a holding temperature of 135 degrees Fahrenheit or greater was maintained. All cold foods were held at 40 degrees Fahrenheit or below.<br><br>During an interview on 4/9/2024 at 11:33 AM, Resident #66 stated they preferred to eat their meals in their room and by the time they received their meals they were usually cold.<br><br>During a resident meeting on 4/9/2024 at 1:35 PM 12 anonymous residents voiced concerns of the meal carts arriving to the units as scheduled, but there was not enough staff to pass out the meal trays timely.<br><br>During an interview on 4/9/2024 at 2:31 PM Resident #4 stated their food was often cold because they required assistance with their meals.<br><br>During an interview on 4/12/2024 at 11:30 AM certified nurse aide #14 stated unit staff passed the meal trays as quickly as they could. How quickly they passed meal trays depended on the number of staff that was on the unit. The meal carts were not separated by where the residents ate their meals.<br><br>During a lunch meal observation on 4/12/2024 at 11:49 AM, the first meal cart arrived at the 3rd floor at 12:00 PM. Resident #66 was served their lunch meal tray. Resident #66's meal tray was tested , and a replacement tray was ordered. At 12:03 PM the milk was measured at 48 degrees Fahrenheit, the apple juice was measured at 47 degrees Fahrenheit, the tossed salad measured at 60 degrees Fahrenheit, and the cut fruit bowl measured 49 degrees Fahrenheit.<br><br>During an interview on 4/12/2024 at 12:16 PM the Food Service Director stated cold food items were supposed to be served at or below 41 degrees Fahrenheit. It was hard to keep cold food items at the proper temperature if they were kept in the same meal cart with the hot food items. The meal cart assembly for the first meal cart on the 3rd floor started at 11:30 AM and there was a 30-minute gap from assembly to the residents being served their meals. They stated the tested cold food items were not served at palatable temperatures.<br><br>10NYCRR 415.14(d)(1)(2)<br><br>48675 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>27522<br><br>Based on observation, record review, and interview during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not ensure storage, preparation, distribution, and service of food in accordance with professional standards for food service safety for 1 of 1 kitchen (the main kitchen) reviewed. Specifically, the main kitchen floors had food debris and were stained; and the clean drying rack had pans that were improperly stacked.<br><br>Findings include:<br><br>The undated Food Service-Receiver Performance Evaluation Form documented that receivers were responsible for weekly freezer cleaning.<br><br>The undated Dietary Supervisor Job Procedure/Description documented from 7:30 PM-8:30 PM the Supervisor would complete a walk-through of the cafe, kitchen, and dish room area, ensuring that all equipment was turned off and clean. Check and lock coolers and doors.<br><br>The Master Cleaning Schedule revised 6/1/0222 documented that a checker was responsible to ensure the walk-in refrigerators were cleaned weekly, and a receiver was responsible to ensure the walk-in freezer was cleaned weekly.<br><br>The following observations were made in the main kitchen on 4/9/2024 between 9:30 AM and 10:30 AM:<br><br>- the floor of the dairy walk-in cooler was stained and sticky.<br><br>- the floor under the walk-in cooler shelves had food items and other debris.<br><br>- there were 3 stacks of pans (18 pans in total) that were stacked on top of each other with the bottom of the pans in contact with the top of the next pan.<br><br>During an interview on 4/12/2024 at 10:00 AM, the Food Service Director stated there were eighteen pans on the clean drying rack that were not being used and should have been moved to the back storage room. They stated having the underside of one pot in direct contact with the cooking side of another pot was a potential contamination source, and the pans were air dried prior to being placed on the clean drying rack. The Food Service Director stated the dairy walk-in cooler, the vegetable walk-in cooler, and the walk-in freezer were all swept 3 times a week and as needed by the stock person. They stated the stock person was responsible for cleaning under the shelves in the coolers and freezer, and for making sure no miscellaneous food items or debris were under the shelves. The Food Service Director stated the night supervisor was responsible for general cleanliness of the kitchen and to make sure it was clean for the next day. They stated the stickiness on the dairy walk-in cooler was caused by a spilled gelatin product that was not cleaned up immediately by the staff who spilled it. The Food Service Director stated the staff who spilled it should have cleaned it up immediately, and not wait for it to be cleaned the next day. They stated that if an issue was identified by a supervisor the next day, they would verbally tell staff to get it fixed, and this was not always documented.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10NYCRR 415.14(h) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44838<br><br>Based on observation, record review, and interview during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 5 residents (Resident #37, #105, and #280) reviewed. Specifically, Resident #280 was admitted to the facility with a diagnosis of COVID-19 and transmission based precautions were not maintained; and Residents #37 and #105 had indwelling medical devices and were not placed on enhanced barrier precautions as required. Additionally, during a medication administration observation licensed practical nurse #8 did not perform hand hygiene between residents.<br><br>Findings include:<br><br>The facility policy Extended Care Facility Transmission Based Precaution Guidelines revised 2/2024 documented standard precautions would be used with every resident in the facility. Other precautions would be utilized depending on the mode of transmission of the organism in question.<br><br>-Standard precautions were to be used for the care of all residents. Hand hygiene was performed before and after resident care regardless of whether gloves were worn.<br><br>-Enhanced barrier precautions included the use of gowns and gloves for high contact resident care activities, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of multi-drug resistant organism colonization as well as well as for residents with multi-drug resistant organism infection or colonization. Examples of high contact resident care activities requiring gown and glove use for enhanced barrier precautions include (but are not limited to): dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care. The procedure included place enhanced barrier precaution sign on the door. Gown and gloves were worn whenever high contact resident activities were performed.<br><br>-Enhanced droplet precautions were to be used in addition to standard precautions if the resident had suspected or confirmed COVID-19. The procedure included place enhanced droplet precautions sign on the outside of the room door with the door closed. Wear N95 mask, eye protection, gown, and gloves while in the resident room (wear surgical mask over the N95 mask to preserve the integrity of the N95 mask).<br><br>1) Resident #280 was admitted to the facility with a diagnosis of COVID-19. The admission Minimum Data Set assessment was not yet completed.<br><br>Physician orders dated 4/3/2024 documented the resident was to be on contact and droplet precautions for COVID-19.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335427 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/12/2024 |
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| Oneida Health Rehabilitation and Extended Care | 323 Genesee Street Oneida, NY 13421 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The comprehensive care plan dated 4/3/2024 documented the resident was on isolation with contact/droplet precautions related to COVID-19 positive testing. Approaches included enforce strict hand hygiene by resident, staff, and visitors, and provide education to resident and staff.<br><br>The resident care instructions (Kardex) documented contact/droplet precautions for COVID-19 illness.<br><br>The following observations were made:<br><br>- on 4/9/2024 at 11:40 AM, unit helper #22 delivered a lunch tray to Resident #280's room. They put on a gown, gloves, and surgical mask before entering. They left the room with the dirty gown in their hand and took it to the dirty utility room. There was no dirty linen receptacle setup in or out of Resident #280's room. The sign outside the room documented enhanced barrier precautions, and not droplet precautions as required for COVID-19. The room door remained open.<br><br>- on 4/9/2024 at 12:27 PM, certified nurse aide #23 took N95 masks to place outside of Resident #280's room. They stated they ran out of them this morning and was supposed to wear them.<br><br>- on 4/10/2024 at 10:02 AM, a dirty linen cart was setup outside of Resident #280's room and the door remained open.<br><br>- on 4/10/2024 at 2:53 PM, unit helper #22 went to answer the resident's call bell. They put on a gown, gloves, and a N95 mask, and did not wear eye protection.<br><br>- on 4/10/2024 at 3:03 PM, licensed practical nurse #16 responded to the resident's call bell. They put on a gown, gloves, a surgical mask, and did not wear eye protection.<br><br>During an interview on 4/12/2024 10:25 AM, unit helper #22 stated transmission based precautions were identified by signs outside of doors. The signs identified the personal protective equipment needed. Resident #280 was on enhanced droplet precautions because of COVID-19. On Tuesday morning (4/9/2024) there were no N95 masks available outside of room. They stated at that time they entered the resident's room wearing a surgical mask and no eye protection. It was important to use proper personal protective equipment to prevent the spread of infection.<br><br>During an interview on 4/12/2024 at 11:05 AM licensed practical nurse #16 stated transmission based precautions were communicated by the sign on the door. Resident #280 was on enhanced droplet precautions for COVID-19. Enhanced droplet precautions for COVID-19 required a N95 mask, gown, goggles (eye protection), and gloves to enter the room to protect yourself and prevent the spread of infection. They stated on 4/10/2024 they just went in the room too fast and did not put a N95 mask on and they should have put on the N95 mask and eye protection. Regular glasses would not provide enough protection and they should have used goggles or a face shield. They were not aware the sign outside of the door was not correct and was not sure who put it up. It was important to have correct signage for all who may enter the room to prevent the spread of infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/12/2024 at 10:38 AM, Registered Nurse Supervisor #13 stated Resident #280 should be on enhanced droplet precautions due to COVID-19. The current sign outside of their room documented enhanced barrier precautions, which was not correct. They were not sure who put the sign up. The incorrect sign made it difficult for staff to know what to wear to protect themselves and prevent the spread of COVID-19. COVID-19 was very dangerous to this population. The personal protective equipment required for enhanced droplet precautions included a gown, gloves, a N95 mask, and eye goggles or a face shield. Personal eyeglasses were not sufficient for protection.<br><br>During an interview on 4/12/2024 at 12:41 PM, Infection Control Preventionist #31 stated infection control education was done at orientation, annually, and on the spot training if needed. Any needs for transmission based precautions were communicated to the Unit Manager, the Director of Nursing, and the Assistant Director of Nursing. They were responsible for ensuring the proper signs and personal protective equipment were placed per policy. COVID-19 positive residents required enhanced droplet precautions. The required personal protective equipment was gloves, gowns, a N95 mask, and eye protection. Hand hygiene should always be performed before and after glove use as well. The facility's population was especially vulnerable to COVID-19 due to risk of complications and possible death from the disease. Enhanced droplet precautions should be adhered to every time, by everyone entering the room. Eyeglasses did not count as eye protection, and staff must wear approved goggles or a face shield.<br><br>2) Resident #37 had diagnoses including acute and chronic respiratory failure with hypoxia (low oxygen levels), tracheostomy (breathing tube), and gastrostomy (feeding tube). The 1/25/2024 Minimum Data Set assessment documented the resident received oxygen, suctioning, tracheostomy care, and invasive mechanical ventilation.<br><br>Resident #37's physician order summary report with active orders as of 4/12/2024 documented tracheostomy size #8 double cannula tube, tracheostomy care every 8 hours, and tracheostomy change as needed. Suction oral secretions as needed. Physician orders did not document enhanced barrier precautions.<br><br>Resident #37's comprehensive care plan revised 5/15/2023 documented the resident was ventilator (breathing machine)/tracheostomy dependent related to respiratory failure and a diagnosis of myotonic dystrophy (progressive muscle wasting and weakness). Enhanced barrier precautions were not documented in the care plan.<br><br>Resident #105 had diagnoses including chronic respiratory failure with hypercapnia (high levels of carbon dioxide in the blood), tracheostomy (breathing tube), gastrostomy (feeding tube), and ventilator (breathing machine) dependence. The 2/25/2024 Minimum Data Set assessment documented the resident received oxygen, suctioning, tracheostomy care, and invasive mechanical ventilation.<br><br>Resident #105's physician order summary report with active orders as of 4/12/2024 documented a urinary catheter 16 French (size) with a 10 milliliter balloon (used to keep the catheter in place); urinary catheter care every shift; a size 8 cuffed double cannula tracheostomy tube; suction oral secretions as needed; a vacuum assisted wound closure device applied every Monday, Wednesday, and Friday for sacral wound; and dressings for lateral ankle wound.<br><br>Resident #105's comprehensive care plan documented:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - on 10/19/2023 the resident had a percutaneous endoscopic gastrostomy tube (feeding tube).<br><br>- on 1/18/2024 the resident had actual impairment to skin integrity.<br><br>- on 2/11/2024 the resident depended on a ventilator.<br><br>Residents #37 and #105 resided together in a room on the ventilator unit.<br><br>The following observations were made:<br><br>- on 4/9/2024 at 12:36 PM, all rooms on the ventilator unit had personal protective equipment caddies and enhanced barrier precautions signs except for Residents #37's and #105's room and room [ROOM NUMBER]. There was no sign present outside of either room indicating enhanced barrier precautions were in place.<br><br>- on 4/10/2024 at 8:48 AM, respiratory therapist #18 was observed going into the residents' room (the ventilator alarm was sounding) wearing gloves and a surgical mask. No enhanced barrier signs were posted outside the room.<br><br>- on 4/10/2024 at 2:01 PM, certified nurse aides #29 and #39 entered Residents #105's and #37's room to provide repositioning and incontinence care to Resident #105. Both certified nurse aides wore only gloves. They did not put on gowns.<br><br>During an interview on 4/12/2024 at 9:35 AM, certified nurse aide #29 stated that care information for residents was found in the care plan and Kardex. Ventilator unit precautions had been changed in the past couple of months. Paper gowns were used to help reduce spread of infection. They stated enhanced barrier precautions were used for any residents with colonized bacteria. If they were not performing personal care up close, staff only needed to perform hand hygiene in and out of the room. Personal protective equipment was used to protect all residents and staff from the spread of infection. Resident #105 was on standard precautions and staff only needed to wear gloves for care.<br><br>During an interview on 4/12/2024 at 9:47 AM, certified nurse aide #30 stated the care plan and Kardex contained all care information needed for resident care. Enhanced barrier precautions meant they could enter the room without personal protective equipment. Gowns, gloves, and a mask were required for hands on care. Contact or droplet precautions required personal protective equipment all the time. They were not sure if Resident #105 was on transmission based precautions.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/12/2024 at 11:59 AM, Assistant Director of Nursing #4 stated transmission based precautions were communicated to staff by the signs placed in front of a resident room. The sign documented the personal protective equipment needed to enter the room. Any staff could request more personal protective equipment if needed. COVID-19 positive residents needed enhanced droplet signs. A registered nurse directed the signage to make sure it was correct. Enhanced droplet precautions required N95 masks, goggles, gown, and gloves. Proper personal protective equipment usage was important to prevent the spread of infection. The population at the facility was vulnerable to infection and COVID-19 was a dangerous disease. Enhanced barrier precautions were just recommendations for residents with a history of multi drug resistant organisms. The Centers for Medicare/Medicaid Services wanted them used for residents with indwelling medical devices such as tracheostomies, urinary catheters, or any wounds. All residents on the ventilator unit should be on enhanced barrier precautions. It was not safe to enter a COVID-19 positive room without proper personal protective equipment.<br><br>During an interview on 4/12/2024 at 12:41 PM, Infection Control Preventionist #31 stated enhanced barrier precautions were implemented in the past 3 months. Enhanced barrier precautions should be followed for anyone with a history of a multi drug resistant organisms, indwelling medical devices, or wounds. Enhanced barrier precautions were used to protect the most vulnerable residents. The ventilator unit should have enhanced barrier precautions in place for every resident. Those residents had a direct portal for infection. Enhanced barrier precautions required gloves, gowns, and a surgical mask for close direct care. The proper use of protective equipment was important to decrease the possibility of spreading pathogens from staff's clothing, hands, or respiratory tract to the residents.<br><br>3) During a medication administration observation with licensed practical nurse #8 on 4/11/2024 from 9:07 AM to 9:52 AM the following was observed:<br><br>- at 9:07 AM, licensed practical nurse #8 exited the dining room and approached the medication cart and wheeled it down the hallway to Resident #381's room. Hand hygiene was not performed after they exited the dining room and before they pushed the medication cart down the hallway. Licensed practical nurse #8 realized they had the wrong medication cart at 9:10 AM, wheeled the incorrect medication cart back to the nurse's station and returned with the correct medication cart at 9:11 AM. The cart was unlocked at 9:12 AM, and 11 medications were emptied from the medication sleeves at 9:15 AM, directly onto the top surface of the medication cart. Licensed practical nurse #8 scooped up the medications with two connected unopened alcohol wipe packages and placed the medications in a plastic medication cup. Miralax was poured from a large bottle and mixed with water. No hand hygiene was performed. At 9:17 AM, licensed practical nurse #8 entered Resident #381's room, hand hygiene was performed, and they handed the medication cup to the resident. The resident requested pain medication. At 9:18 AM, licensed practical nurse #8 exited the room, did not perform hand hygiene, and prepared the requested 2 pain medication pills for Resident #381. At 9:19 AM, licensed practical nurse #8 returned to Resident #381's room and did not perform hand hygiene. At 9:20 AM, licensed practical nurse #8 touched their lips with their hand to blow the resident's roommate a kiss. At 9:21 AM, licensed practical nurse #8 exited the room, hand hygiene was not performed, and they went back to the medication cart and unlocked it. The cart was then wheeled to Resident #118's room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - at 9:22 AM, licensed practical nurse #8 performed hand hygiene with an alcohol-based rub located outside of Resident #118's room. At 9:27 AM, the medication packages were opened, 8 medications were placed in a plastic medication cup, and one was later removed as they did not see an active order for it. Miralax was mixed with water. At 9:29 AM, the nurse locked the cart and entered Resident #118's room and administered the medications. At 9:31 AM, the nurse exited the resident's room, and did not perform hand hygiene. The nurse re-entered the room and asked the resident if they had any pain. At 9:34 AM, the nurse exited the room, did not perform hand hygiene, and disposed of a medication they did not provide, and returned to the medication cart.<br><br>- At 9:38 AM, licensed practical nurse #8 locked the medication cart and went down the hall and obtained a blood pressure machine. At 9:39 AM, the nurse entered Resident #44's room with the blood pressure machine and did not perform hand hygiene. Resident #44 was on enhanced barrier precautions for an undocumented condition. The resident had an enhanced barrier precaution sign outside the room next to the door frame that instructed everyone who entered or exited the room to perform hand hygiene. At 9:40 AM, the resident's blood pressure was obtained and at 9:42 AM, the nurse left the room and did not perform hand hygiene. At 9:47 AM, licensed practical nurse #8 poured Resident #7's medications into a plastic medication cup with applesauce. At 9:48 AM, the nurse entered the resident's room with the medications and did not perform hand hygiene. The resident requested pain medication and at 9:48 AM, the nurse exited the resident's room, and did not perform hand hygiene. At 9:49 AM, the nurse returned to the medication cart and prepared the additional 2 medication pills and returned to the resident's room and did not perform hand hygiene. At 9:50 AM, the additional medication was provided to the resident. At 9:51 AM the nurse handed the resident their ordered inhaler. At 9:52 AM, licensed practical nurse #8 exited the room and returned to the medication cart and did not perform hand hygiene.<br><br>During an interview on 4/11/2024 at 9:53 AM, licensed practical nurse #8 stated they should have performed hand hygiene in between each resident to prevent the spread of infection. They did not perform hand hygiene in between residents but they should have to prevent the spread of germs. They were not sure what enhanced barrier precautions were or why Resident #44 was on precautions. They confirmed after reading the enhanced barrier precaution signage that they should have performed hand hygiene each time they entered or exited the room.<br><br>During an interview on 4/12/2024 at 12:12 PM, Infection Control Preventionist #31 stated hand hygiene should be performed in between residents when medications were passed. Hand sanitizers were located on the medication carts and outside of all resident rooms. It was important because lack of hand hygiene was the leading way infections were prevented. If hand hygiene was not performed it could put the residents at risk for infections. It was important that hand hygiene was performed before entering enhanced barrier precaution rooms as it prevented the spread of germs/infection. Hand hygiene should be performed again when exiting the room because it prevented the spread of germs from the resident to anyone outside of the room. Everyone was at risk for infection if the nurse did not perform hand hygiene. Appropriate hand hygiene was discussed in orientation, during in-services, and when any issues were identified.<br><br>10 NYCRR 415.19(a)(2)<br><br>48675<br><br>49448 |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>27522<br><br>Based on observation, record review, and interview during the recertification survey conducted 4/9/2024-4/12/2024, the facility did not maintain an effective pest control program so that the facility was free of pests in four isolated areas (the main kitchen, and the 2nd, 3rd, and 4th floor tub rooms) reviewed. Specifically, there were fruit flies in the main kitchen and drain flies in the 2nd, 3rd, and 4th floor tub rooms.<br><br>Findings include:<br><br>The third-party pest control vendor service inspection reports from 11/17/2023 to 4/10/2024, did not include documentation of the presence of fruit flies or drain flies in the facility.<br><br>The facility's Pest Activity/Sightings Log documented that fruit flies were present in the main kitchen on 1/4/2024, 2/12/2024, 3/22/2024, 4/2/2024, and 4/5/2024.<br><br>The following observations were made:<br><br>- on 4/9/2024 at 9:30 AM, the main kitchen had 15 live fruit flies by dish machine area.<br><br>- on 4/9/2024 at 11:55 AM, the 4th floor tub room had 3 live drain flies and multiple dead drain flies on the floor.<br><br>- on 4/9/2024 at 12:18 PM, the 2nd floor tub room had 15 live drain flies.<br><br>- on 4/9/2024 at 12:50 PM, the 3rd floor tub room had 10 live drain flies and multiple dead drain flies on the floor.<br><br>During an interview on 4/12/2024 at 10:35 AM, the Environmental Services Manager stated they were not aware there were drain flies in the 2nd, 3rd, or 4th floor tub rooms. They stated the tub rooms on the 2nd, 3rd, and 4th floors were actively used by residents. The Environmental Services Manager stated the fruit fly traps in the 4th floor tub room were not put there by the environmental services department or the maintenance department. They stated they expected staff to report pests found in the facility via a phone call, and they would then contact the pest control vendor. They were aware of fruit flies in the main kitchen and was not aware that the main kitchen had its own internal pest log sheet. They stated, between 11/17/2023 and 4/10/2024, the monthly pest control vendor service inspection reports did not document any fruit flies or drain flies. It was important that pest maintenance was maintained for comfort and safety of residents and staff.<br><br>10NYCRR 415.29(j)(5) |