STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335427	A. Building B. Wing	01/27/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for four (4) out of twelve (12) kitchen staff (Dietary Aides #14, #15, #16, and #17). Specifically, Dietary Aides #14, 15, 16, and 17 had improper hair restraints while preparing food and meal trays in the main kitchen. Findings include:The facility policy Sanitation and Infection Control, revised 05/2023, documented employees would wear hair restraints. Men with beards and/or mustaches would wear beard restraints. The following observations of improper hair restraints were made in the main kitchen on 01/20/2026 at 11:02 AM: -Dietary Aide #14 was walking through food preparation areas with an unrestrained long ponytail. -Dietary Aide #15 was preparing food in the front of the kitchen wearing only a cap on their head, with long, shoulder length hair untied or restrained.-Dietary Aide #16 was preparing lunch trays for residents wearing only a cap on their head, with long shoulder length hair untied or restrained.-Dietary Aide #17 was preparing lunch trays for residents wearing only a cap on their head, with long shoulder length hair untied or restrained. During an interview on 01/21/2026 at 2:46 PM, Resident #13 stated they found a hair in their pasta at lunch that day. They stated it ruined their appetite. During an interview on 01/22/2026 at 8:23 AM, Food Service Director #19 stated staff needed to either wear a hair net or a hat. If the hair was under 18 inches long, they could wear just a cap. When long hair was only covered with a cap, it did not prevent hair from falling into the food. During an interview on 01/27/2026 at 7:50 AM, Dietary Aide #18 stated the policy for restraining hair was to contain hair in a hair net or wear a baseball cap. They stated when food was present, they could wear either one, regardless of hair length. During an interview on 01/27/2026 at 12:54 PM, Dietary Aide #15 stated the hair restraint policy was to wear a hair net on longer hair and a cap only with short hair. They stated preparing food with their long hair not completely restrained was an oversight, as they were trying to hurry to work. During an interview on 01/27/2026 at 1:00 PM, Food Service Director #19 stated hair needed to be fully restrained in the main kitchen. 10 New York Codes, Rules and Regulations 415.14(h)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on observations, record review, and interviews during the recertification survey, the facility failed to establish mechanisms for documenting and communicating the resident's choices regarding Advance Directives to the staff responsible for the resident's care for one (1) of thirty-three (33) residents (Resident #63) reviewed. Specifically, Resident #63's electronic Medical Orders for Life-Sustaining Treatment form (a medical order for wishes for life-sustaining treatment completed by a medical provider) documented the resident consented to do not resuscitate (allow natural death) and the resident's electronic medical record documented to attempt cardiopulmonary resuscitation (attempt to restart the heart). Findings include: The facility policy Advance Directives: Advance Care Planning for Healthcare Decisions, revised 7/2024, documented medically appropriate care would be provided to every patient and patient's wishes regarding cardiopulmonary resuscitation and do not resuscitate and other life sustaining treatment and end of life health care decisions would be honored. Resident #63 had diagnoses including metabolic encephalopathy (a brain dysfunction) and diabetes. The 8/14/2025 Minimum Data Set assessment documented that the resident had moderately impaired cognition. The resident was previously admitted to the facility in 1/2025 at which time had an advance directive of Do Not Resuscitate, was discharged home, and was readmitted to the facility from the hospital in 1/2026. The 01/12/2026 physician order documented the resident was a full code. The 1/12/2026 at 8:26 PM Physician # 25 progress note documented the resident was admitted to the facility for rehabilitation after an acute visit to the hospital. The resident wanted to be a full code (receive cardiopulmonary resuscitation if their heart stopped) but there was a previous electronic Medical Orders for Life-Sustaining Treatment which documented do not resuscitate. The resident would remain a full code until it could be reassessed in the morning, and a final decision could be made. The 1/13/2026 Comprehensive Care Plan, revised 1/21/2026, documented full code status with interventions to include cardiopulmonary resuscitation. The 1/13/2026 at 2:38 PM Registered Nurse Unit Manager #22 Clinical admission progress note documented the resident was alert and oriented and was able to understand and be understood when speaking. There was no documentation of the resident's advance directive wishes or verification of wishes. The 1/14/2026 at 1:26 PM Social Worker #35 Plan of Care note documented the resident's admission packet, and all assessments were completed. There was no documentation regarding the resident's advance directive wishes. The 1/21/2026 Medical Orders for Life Sustaining Treatment form documented the resident verbally consented to a do not attempt resuscitation order in the event their heart stopped. The form was signed by Physician #25 on 1/21/2026. During an interview and observation on 1/21/2026 at 11:14 AM, Resident #63 had a bracelet on their left wrist with a red heart on it. They stated they did not know what the bracelet was for. Staff did not ask them if they wanted cardiopulmonary resuscitation. They did not want cardiopulmonary resuscitation and could make their own decisions. During an interview on 1/21/2026 at 11:18 AM, Certified Nurse Aide #23 stated the residents that had bracelets with hearts on them were the residents who wanted to receive cardiopulmonary resuscitation. During an interview on 1/21/2026 at 11:24 AM, Licensed Practical Nurse #7 stated they would start cardiopulmonary resuscitation on an unresponsive resident if they had the red heart bracelet on. The red heart bracelet meant they were a full code. During an interview on 1/21/2026 at 1:56 PM Registered Nurse Manager #22 stated on admission, residents were asked about advance directives preferences. If they want to be full code, an order was put in and a bracelet was placed on the resident. If there was a preexisting Medical Orders for Life Sustaining Treatment and the resident's preferences had not changed then a new Medical Orders for Life Sustaining Treatment did not need to be generated, however if preferences changed then a new one should be generated. During Resident #63's admission assessment the resident told them they wanted to be a full code. They notified Physician #25 who came the next day. Physician #25 left them a note asking (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them to clarify the resident's preferences as the resident told them they preferred not to be resuscitated. It was not determined who was to make that clarification and was not sure if anyone did. After referring to eMOLST (a web-based application where Medical Orders for Life Sustaining Treatment are uploaded to), they stated the resident's Medical Orders for Life Sustaining Treatment documented do not resuscitate but their order in the electronic medical record was full code. If the resident's heart stopped, they would be resuscitated. They thought they did not generate new Medical Orders for Life Sustaining Treatment because there must have been too many hands in the pot during the admission process. During an interview on 1/21/2026 at 2:45 PM, Social Worker #35 stated usually within 24 hours of a new admission they met with the resident to review advance directives and made sure the order was what the resident wanted. This was documented in either a care plan or a progress note. They met with Resident #63 but did recall the exact conversation. The resident's order documented full code. They assumed the resident told them they wanted to be a full code because that was what was in their care plan. They did not write a progress note, but they should have. During an interview on 1/21/2026 at 3:11 PM, Physician #25 stated they discussed advance directives during their admission visit. The eMOLST was started by nursing, and they filled in the rest and signed it off. During Resident #63's admission visit, the resident's verbalized an advance directive preference that was contrary to what was on their current Medical Orders for Life Sustaining Treatment. Therefore, they did not sign it and instead told the charge nurse it needed to be clarified. On 1/20/2027, Registered Nurse Manager #22 told them the resident's preferences were clarified, and it was okay to go ahead and sign the Medical Orders for Life Sustaining Treatment. They took that to mean that it was clarified and that the resident did not want to be resuscitated so they signed it. The Medical Orders for Life Sustaining Treatment and the orders should match, and it was the responsibility of the charge nurse to make sure they did. If orders did not match what was on the Medical Orders for Life Sustaining Treatment, those orders should be changed immediately. 10 New York Codes, Rules and Regulations 400.21(c)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interviews during the recertification survey, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to include services provided to maintain the resident's highest practicable physical well-being for one (1) of one (1) resident (Resident #144) reviewed. Specifically, Resident #144's person-centered comprehensive care plan did not include the diagnoses of type 2 diabetes mellitus (the body does not use insulin properly causing high blood sugars), the use of insulin (used to treat high blood sugars), or the use of an anticoagulant (blood thinner).Findings include:The facility policy Comprehensive Care Plans, revised 04/2024, documented the facility would develop a comprehensive individualized plan of care for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. Care plans would be reviewed and updated at least quarterly, when there was a significant change in the resident's condition, and as needed. Goals, objectives, and interventions would be reviewed and revised by the interdisciplinary team when there was a change in planned interventions, a new diagnosis, new medications or abnormal labs.Resident #144 had diagnoses diabetes and atrial fibrillation (irregular heartbeat). The 01/02/2026 Minimum Data Set assessment documented the resident was cognitively intact, received daily insulin injections, and was on an anticoagulant.Physician orders documented:-on 12/26/2025 Lantus (long-acting insulin) 5 units subcutaneously (under the skin) once daily for diabetes.-on 12/26/2025 insulin lispro (short acting insulin) 5 units subcutaneously before meals for diabetes.-on 12/26/2025 apixaban (blood thinner) 5 milligram tablet by mouth two times a day for atrial fibrillation.There was no documented evidence of a person-centered comprehensive care plan that included the diagnosis of diabetes with the need for insulin administration and monitoring for hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar), and the use of an anticoagulant or monitoring for symptoms and side effects of anticoagulant use. During an interview on 01/27/2026 at 12:12 PM, Licensed Practical Nurse #5 stated all nursing staff were able to review care plans, but the registered nurses were responsible for initiating and updating them. Medications including anticoagulants and insulin should be included in Resident 144's care plan so staff would know to monitor for increased bleeding and bruising or signs of hypoglycemia.During an interview on 01/27/2026 at 12:35 PM, Registered Nurse Manager #4 stated care plans were initiated by a registered nurse upon admission and were reviewed and updated quarterly and as needed. Licensed practical nurses were not allowed to initiate care plans, but they could update them. All staff were expected to review care plans because they told them everything about the residents, and how to properly care for them. Resident #144 was a diabetic who received insulin and was on an anticoagulant for atrial fibrillation. They were not aware the resident's care plan did not include their insulin or anticoagulant use, but it should have so staff would know to monitor for bleeding or bruising, and for signs of hypoglycemia or hyperglycemia.10 New York Codes, Rules and Regulations 415.11(c)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, record review, and interviews during the recertification and abbreviated (IQIES 466495) surveys, the facility failed to ensure residents' medications were administered in accordance with accepted professional standards and the prescriber's order for two (2) of two (2) residents (Residents #1 and #39) reviewed. Specifically, Resident #1's and #39's physician orders did not include the amount of fluid used with medication instillation; and Resident #1 was administered ginger ale with medications without a physician order.Findings include:The facility policy Enteral Nutrition, last revised 02/2025 documented adequate nutritional support through enteral nutrition (feeding tube) would be provided to residents as ordered. The dietitian, with input from the provider and nurse calculates the fluids to be provided. Complete orders include instructions for flushing (solution, volume, frequency, timing and 24-hour volume). Documentation of the feedings and flushes will be under the medication administration record in the electronic medical record. 1)Resident #39 had diagnoses including gastrostomy tube and cerebral palsy (affects motor function). The 09/08/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, had a gastrostomy feeding tube, and received 51% of total calories and 501 milliliters per day or more average fluid intakes by feeding tube. The 12/24/24 comprehensive care plan documented the resident had a gastrostomy tube and was at risk for fluid deficit related to the gastrostomy tube. Interventions included estimated fluid needs of 1080 milliliters per day, monitor and document intakes and outputs, provide tube feedings and water flushes per physician orders, enteral tube feedings at 48 milliliters per hour, and see physician orders for tube feeding flushes and rates. The 12/23/2024 physician orders documented flush gastrostomy tube every 6 hours with 60 milliliters of water, flush gastrostomy tube with 30 milliliters of water before and after medications, document amount of formula and water provided every eight (8) hours. The order did not include the amount of water used with the medication instillation. The 01/2026 Medication Administration Record did not include how much water to mix the medications in tablet form with when administering via the feeding tube. During a medication administration observation and interview on 01/27/2026 at 1:07 PM, Licensed Practical Nurse #40 prepared Resident #39's Reglan (treats reflux) 5 milligram one tablet to administer via gastrostomy tube. They checked the medication orders, crushed the tablet, mixed the powder with 60 milliliters of tap water, checked the tube for placement, provided 30 milliliters of tap water via syringe and gravity, administered the medication, and flushed the tube with another 30 milliliters of tap water. They stated there was no order for how much water to use for medication dilution. The nurse stated they gave the resident their medications that morning, crushed them all together, and used 60 milliliters of tap water to dilute them. Licensed Practical Nurse #40 stated without an order for how much fluid to give the medication with the amount could vary from nurse to nurse and affect daily intake amounts. During an interview on 01/27/2026 at 1:27 PM, Registered Nurse Manager #36 stated there should be an order for water to dilute each medication with. The dietitian calculated daily fluid needs, so staff needed to monitor how much fluids the resident was taking in daily. The provider was responsible for entering the order of how much fluid to dilute the medications. They stated they were responsible for reviewing the orders quarterly and did so last on 12/24/2025. They did not notice the residents did not have an order for diluting the medications. After reviewing the gastrostomy medications order set, the manager stated there was no order regarding how much water to use to dilute each medication and that dietary usually entered the flushes order set. 2)Resident #1 had diagnoses including gastrostomy tube (feeding tube) and persistent vegetative state. The 12/30/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, had a gastrostomy feeding tube, and received 51% of total calories and 501 milliliters per day or more average fluid intakes by feeding tube. The 07/15/2020 comprehensive care plan, updated 12/29/2025, documented the resident had a gastrostomy tube and was at risk for fluid deficit related to the gastrostomy tube. Interventions included total dependance on staff for tube feedings and all (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water flushes to meet their nutritional needs. This included providing enteral feedings, medications as ordered, water flushes to meet estimated fluid needs of 2130 milliliters per day, and documenting intake and output. The 06/14/2025 physician orders documented enteral nutrition orders through their gastrostomy tube included bolus feeds every 4 hours at a rate of 300 milliliters over an hour via pump, a 250-milliliter water flush every shift, and a water flush of 30 milliliters before and after each medication pass and bolus feed. The order did not include the amount of water used with the medication instillation. The 01/2026 Medication Administration Record did not include how much water to mix the medications in tablet form with when administering via the feeding tube. During a medication administration observation and interview on 01/23/2026 at 10:58 AM, Licensed Practical Nurse #34 provided a 30-milliliter water flush, then checked the pump and initiated the enteral feeding for 300 milliliters over the hour. They said after the hour ends, if there is any formula still in the tube they flushed it with another 30 milliliters of water before disconnecting the tube. They said the 250 milliliter water flushes per shift would kick in automatically by the pump. They had already passed the medications that morning and the next medication pass was later in the afternoon. They stated they provided 30 milliliters of water before and after the medication pass and always mixed the crushed meds together with 120 milliliters of ginger ale. They did not have an order for how much fluid to dilute the crushed medications with, or to use ginger ale with medications. They stated any water flushes they administered should be in the orders, including what and how much fluid should be mixed with the medication. They stated that information is missing from the order, so they just give a standard of 240 milliliters of water in that case. They used 120 milliliters of ginger ale instead of 240 milliliters in this case because it just worked better and they used 240 milliliters of water with the Nutrisource Fiber and Juven packets. There was no documented evidence of a physician order for the resident to receive ginger ale with medication administration. During an interview on 01/23/2026 at 11:23 AM, Registered Nurse #13 stated the dietitian wrote all the enteral orders for feedings and water flushes. The nurses just followed the medication administration record when providing the enteral feeding. There should be orders for how much fluid to mix the medications with. For the Nutrisource Fiber and Juven, they followed the packet instructions when there was no order. During a medication administration observation and interview on 01/27/2026 at 7:30 AM, Licensed Practical Nurse #34 had just finished administering all the medications crushed and mixed in ginger ale and was giving the 30 milliliter post medication pass flush. They stated they mixed all the morning meds together with the ginger ale, combined in the cup and administered them all together. During an interview on 01/27/2026 at 10:59 AM, Registered Dietitian #11 stated they knew how many medication passes a resident received daily by looking at the medication administration record. They stated they wrote the enteral order for feeding and water flushes and there are specific water flush amounts for before, with, and after medications, and before and after feedings. Nutrisource Fiber and Juven should be mixed with 240 milliliters to administer, and this should be part of the order. Resident #1 received 30 milliliters before and after medication passes but was not sure how much was mixed with medications. They stated they did not determine how much or what fluid would be provided with the medications but there should be an order for it. All fluids put through the tube should be recorded on the medication administration record, including fluids mixed with medications and supplements. During an interview on 01/27/2026 at 12:05 PM, Licensed Practical Nurse #37 stated when they administered medications through an enteral tube, they usually mixed all the crushed medications together with approximately 60 milliliters of ginger ale. They were not sure if mixing ginger ale with any medications was contraindicated. They were not sure how much water was mixed with Nutrisource Fiber or Juven because there was no order, and they used 120 milliliters to mix those products. If a specific amount was necessary, it would have been part of the order. 10 New York Codes, Rules and Regulations 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews during the recertification survey (Complaint #2699879), the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection and prevent new ulcers from developing for one (1) of two (2) residents (Resident #76) reviewed. Specifically Resident #76 had two Stage 2 pressure ulcers (partial-thickness skin loss) on the buttocks and an unstageable (full thickness tissue loss in which the base of the ulcer is covered with dead tissue) pressure ulcer on the right heel that did not have timely treatment orders or interventions; the medical orders for wound treatments were not followed; and the resident was not turned and positioned as planned. Findings include: The facility policy Prevention and Treatment of Pressure Injuries, last reviewed 9/2025, documented the facility would develop and implement a comprehensive care plan that reflected each residents identified needs and effort to stabilize, reduce or remove the underlying risk factors; interventions would be identified and modified as appropriate and ensure residents with pressure injuries received the necessary treatment and services to promote healing and/or prevention infection. Additionally, a pressure injury was considered avoidable if the facility did not do any of the following: evaluate the resident's clinical condition and pressure injury risk factors; define and implement interventions that were consistent with the resident's needs, goals and recognize the standard of practice; monitor and evaluate the impact of the interventions; and revise the approaches as appropriate.Resident #76 had diagnoses including obesity, anemia, and peripheral vascular disease (poor circulation). The 12/19/2025 Minimum Data Set assessment (assessment tool) documented the resident's cognition was intact; required maximum assistance for bed mobility; was at risk for pressure ulcers; did not have any pressure ulcers; had two venous/arterial ulcers; had a pressure reducing device for chair and bed; and applications of nonsurgical dressing, ointments and medications. The unsigned 12/16/2025 Braden scale (a tool used to determine risk for pressure injuries) documented the resident was at high risk for developing a pressure ulcer.The unsigned 12/16/2025 Clinical admission assessment documented the resident had an abrasion to the right heel. There was no further documentation related to any other skin alterations. The 12/18/2025 Comprehensive Care Plan documented the resident had an infection on both lower extremities and was at risk for pressure ulcers. The infection interventions included follow up with the wound clinic and betadine (a topical antiseptic) to the right heel and leave open to air. Pressure ulcer interventions included weekly skin inspections, a flat bed, follow the facility protocols for prevention/treatment of skin breakdown, and the resident preferred the use of two staff for repositioning. The undated Kardex (care instructions) documented weekly skin inspections, keep the bed in a flat position, follow the facility protocols for prevention/treatment of skin breakdown and turn and position every two (2) hours. BUTTOCKS: The unsigned 12/16/2025 Skin Alert/Body Alert assessment documented there was a Stage 2 (partial thickness loss of skin) pressure ulcer on the right buttock and one on the left buttock, both measuring 1 x 1 centimeters. There was no treatment ordered or any further documentation related to the Stage 2 pressure ulcers on the buttocks until 12/24/2025. The 12/24/2025, weekly wound rounds documented the resident had a Stage 2 on the right buttock measuring 3 x 2 centimeters with no drainage, foul odor or surrounding redness. An addendum on 12/28/2025 documented the resident had a Stage 2 on the left buttock measuring 3.5 x 2.5 centimeters with no drainage, foul odor or redness. The plan was to offload and monitor weekly. The 12/24/2025 physician order documented cleanse both buttocks with soap and water, pat dry and apply A & D ointment every shift and as needed for Stage 2 pressure ulcers. The 12/31/2025 weekly wound rounds documented a Stage 2 on the right buttock measuring 8 x 3.5 centimeters and the wound base contained healing tissue. Puracol powder (a topical wound treatment), off load and monitor weekly. An addendum dated 01/01/2026 documented the resident had a Stage 2 area on the (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left buttocks measuring 9 x 4 centimeters, with no drainage. The plan was to change the treatment to Puracol powder, off load and monitor weekly. The 12/31/2025 Physician Order documented to cleanse both buttocks with soap and water, pat dry, then apply Puracol powder to wounds every shift and as needed. The 01/07/2026 weekly wound rounds documented a Stage 2 pressure ulcer on the right buttock measuring 13.5 x 5 x 0.5 centimeters with no drainage or odor, and healing tissue to the wound bed. A Stage 2 pressure ulcer to the left buttock measuring 11.5 x 4.5 centimeters with no drainage or odor and some healing tissue to the wound bed. The plan for both pressure ulcers was to continue treatment, offload and monitor weekly. The 1/12/2026 Wound Clinic Consult Report documented the resident had a Stage 3 (full thickness tissue loss) pressure injury to both buttocks with copious drainage and Mupirocin (ointment) and Optifoam (dressing) change daily was recommended. The 1/15/2026 Physician Order documented to clean both buttocks with soap and water, pat dry and apply Muoiricin and cover with Optifoam daily for a Stage 3 pressure ulcer. The 1/20/2026 Wound Clinic Consult Report documented the Stage 3 pressure injuries to both buttocks were excoriated, foul odor and has purulent (pus) drainage. Recommendations were to cover the wounds with Optifoam, change daily, turn and reposition every two (2) hours and limit the resident's time on their bottom. Doxycycline (antibiotic) was ordered for 10 days. RIGHT HEEL: The unsigned 12/16/2025 Clinical admission assessment documented an abrasion to the right heel. There was no further description of the area. There was no documented evidence of any monitoring of the right heel abrasion that was identified on 12/16/2025.Physician orders documented the following:-On 12/17/2025 skin prep (protective barrier) to both heels twice a day for prevention. -On 12/17/2025 float heels while in bed every shift.There was no documented evidence that the intervention to float heels was added to the resident's comprehensive care plan or Kardex. The unsigned 01/6/2026 Skin Alert/Body Alert assessment documented a 5 x 4-centimeter unstageable (full thickness tissue loss in which the base of the ulcer is covered with dead tissue) pressure ulcer to the right heel. The 01/20/2026 Wound Clinic Consult Report documented the unstageable pressure ulcer on the right heel contained dry dead tissue. Recommendations included to apply and change heel cup daily, limit head of bed up to 30 degrees, and float heels as much as possible. The 01/20/2026 physician order documented apply heel cup to right heel daily. The 01/2026 Treatment Administration record documented:-cleanse bilateral buttocks with soap and water, pat dry, apply Muoiricin and cover with Optifoam once daily. -heel cup to right heel, change daily. There was no documented evidence that the heel cup was changed on 01/21/2026. -skin prep to heels two times daily. There was no documented evidence that the skin prep was applied during the day shift on 01/21/2026. -float heels. There was no documented evidence that the heels were floated on 01/21/2026 during the day shift on 01/21/2026. During an observation on 01/22/2026 at 2:35 PM, Licensed Practical Nurse #21 performed a dressing change to the resident's right heel and buttocks. The right heel did not have a heel cup in place. Licensed Practical Nurse #21 cleansed the heel with sterile water and covered the wound with Opticell (a type of dressing), applied the heel cup, and wrapped with kerlix. They did not apply skin prep. Licensed Practical Nurse #21 rolled the resident onto their right side to perform wound care to the buttocks. The old dressing was removed and was fully saturated with brown drainage. The old dressing was not Optifoam dressing. There were a foul odor and the brown drainage extended onto the absorbent pad underneath the resident saturating about 25% of the pad. During an interview on 01/22/2026 at 4:23 PM, Licensed Practical Nurse #21 stated they were not sure what product the old dressing they removed was. They referred to the orders and stated they applied Opticell to the wound when there was only an order for a heel cup. They applied Opticell in the past and they assumed the order was the same. They should have double-checked the orders before doing the treatment and should follow current orders not previous ones. During an observation and interview on 01/23/2026 at 7:59 AM, the resident was lying on their back in bed. Both heels were resting directly on the bed. Registered Nurse Manager #22 entered the room and stated the heels were not floating but they should be. During a continuous observation on 01/23/2026 from 9:30 AM to 1:30 PM, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident was lying on their back in bed and was not turned and repositioned. During an interview on 01/23/2026 at 1:44 PM, Certified Nurse Aide #23 stated Resident #76's skin on their buttocks was open and they should be turned and repositioned every two (2) hours. They did not turn and reposition the resident today because they could not get to it. They should have turned the resident every two hours and reported to the nurse that it did not get done. During an interview on 1/23/2026 at 1:56 PM, Licensed Practical Nurse #24 stated residents should be repositioned every two (2) hours and heels floated unless care planned differently. The aides were responsible for doing that and if it was not being done it should be reported to them. Resident #76 had wounds, and they should be repositioned frequently. They should not be left in the same position for four (4) hours as it could worsen their wounds. It had not been reported to them that the resident was not repositioned. During an interview on 01/27/2026 at 12:12 PM, Registered Nurse Manager #22 stated any open areas noted on admission would be measured and documented in the clinical admission assessment; non pressure wounds should have a weekly progress note as to the status of the wound by a registered nurse to include measurements; pressure ulcers were reported to the provider immediately as that was the only way to get a treatment order; residents at high risk for skin breakdown should have a potential for skin breakdown care plan with specific preventative interventions; residents with a pressure ulcer should have an actual skin impairment care plan with specific interventions; and they were responsible for making sure those care plans were up to date. Resident #76, on admission, was at high risk for skin breakdown and had stage 2 buttock pressure ulcers and an abrasion to their right heel. The buttock wounds should have had a care plan, treatment, a provider note, and interventions in place prior to 12/24/2025. The heel should have been monitored but they did not see documentation that it was. A chair cushion was put in place on admission, but things like heel floating and turning every 2 hours would not be listed because they were considered standards of care. The resident should not be left in the same position for 4 hours or have any blanks on their treatment administration record as that implied the treatment was not done. During an interview on 01/27/2026 2:56 PM, Physician #25 stated on admission they asked the nurses if there were any skin concerns they needed to look at. They expected preventative skin measures to be put in place for a high-risk resident immediately on admission. They expected if the resident was admitted on [DATE] with an open area to their heel, there would be monitoring notes regarding its status prior to 01/6/2026 when the heel was found to be black and unstageable. They expected interventions to be in place for the open areas on the buttocks immediately. During an interview on 01/27/2026 at 3:40 PM, the Director of Nurses stated on admission the registered nurse did the first skin assessment and Braden scale. If at risk, a care plan with specific interventions such as turn and reposition, skin prep, and floating heels should be put in place within 24 hours. If there was an open area, then an actual skin impairment care plan should be initiated with specific interventions. They expected if a resident was assessed to be a high risk for skin breakdown and had two Stage 2 pressure ulcers to their buttocks and an abrasion on their heel that a care plan with specific interventions was put in place right away. The heel should have been followed by a registered nurse weekly and a progress note entered prior to 01/6/2026 when it was documented as an unstageable pressure ulcer. 10 New York Codes, Rules and Regulations 415.12(c)(1)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, record review, and interviews during the survey conducted 01/27/2026-01/27/2026, the facility failed to ensure an indwelling urinary catheter (removes urine from the bladder) was not used unless there was valid medical justification for one (1) of three (3) residents (Resident #18) reviewed. Specifically, Resident #18 had an indwelling catheter without an order, indication, or care plan for its usage.Findings include:Resident #18 had diagnoses including congestive heart failure (the heart does not pump efficiently), chronic kidney disease, and acute cystitis (inflammation of the bladder). The 12/05/2025 Minimum Data Set assessment (screening tool) documented the resident had severely impaired cognition, required maximum/dependent assistance for all activities of daily living and transfers, and did not have an indwelling catheter.Resident #18 was observed with a urinary catheter on 01/20/2026 at 11:58 AM and 01/21/2026 at 8:45 AM. The unsigned 01/16/2026 admission Assessment documented Resident #18 did not have an indwelling urinary catheter.There was no documented physician admission order for an indwelling catheter including size, care, or rationale for use. There was no documented evidence of urinary catheter care plan or care instructions (Kardex) for urinary catheter care. The 01/19/2026 Physician #9 progress note documented Resident #18 had a new urinary catheter placed while in the hospital.During an interview on 01/27/2026 at 11:40 AM Certified Nurse Aide #6 stated urinary catheter care should be on the Kardex. Resident #18 had a urinary catheter, but they did not notice if it was on their Kardex. During an interview on 01/27/2026 at 11:45 AM Licensed Practical Nurse #7 stated urinary catheters should be in the care plan and the Kardex. Catheter orders consisted of the size, the size of the balloon, and the reason for the catheter. They stated Resident #18 had a urinary catheter and they were not sure why they had one. Licensed Practical Nurse #7 confirmed there were no physician orders for the urinary catheter. During an interview on 01/27/2026 at 12:00 PM Registered Nurse #8 stated the licensed practical nurses cared for the urinary catheters and changed them every 30 days per the physician order. Urinary catheters should also be included in the care plan and in the Kardex so urinary output could be documented in the task. When residents were admitted with urinary catheters, orders were placed with a reason why the resident had the catheter. If there was no reason why, nursing needed to find a reason or receive orders to have it removed. They needed to know when it was inserted or last changed so they knew when it had to be changed again. Resident #18 had a urinary catheter. They confirmed there were no physician orders, a diagnosis, or care plan for a urinary catheter. 10 New York Codes, Rules and Regulations 415.12(d)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (1) of three (3) residents (Resident #101) reviewed. Specifically, Resident #101 had significant weight loss and did not have a timely nutritional assessment. Findings include: The undated facility policy Nutritional Assessment and Reassessment, documented residents would receive timely and accurate nutrition assessments, including residents with significant nutritional changes.The facility policy Weights, revised 03/2022, documented nursing staff measured resident weights on admission, and weekly for four weeks. If no weight concerns, weights were then measured monthly. Dietary and medical providers would be notified of any weight discrepancies. Weight loss greater than five percent in one month or greater than ten percent in six months were severe.Resident #101 had diagnoses including dementia, chronic respiratory failure, and vascular disease. The 08/19/2025 Minimum Data Set (assessment tool) documented the resident had severe cognitive impairment, had symptoms of social isolation and depression, required supervision for eating, weighed 163 pounds, and had no weight change.The resident's weight record documented the following weights: -06/02/2025, 173.2 pounds-07/01/2025, 168 pounds-08/19/2025, 162.8 pounds-09/10/2025, 159.9 pounds (7.7% loss in 3 months)-10/08/2025, 161.2 pounds-11/07/2025, 157.6 pounds-12/02/2025, 154.2 pounds (11% loss in six months)-01/24/2026, 147.6 pounds (4.3% loss in one month and 12.2% loss in six months). The 08/13/2023 Comprehensive Care Plan, revised 11/25/2025, documented the resident had potential for altered nutritional status due diagnoses and poor intakes. On 09/11/2025 the resident had significant weight loss of 7.6% in 90 days. Interventions included two English muffins and two peanut butter at breakfast; Eight ounces of Ensure (nutritional supplement) and pudding at supper; and eight ounces of milk with three meals. The weight goal was 160 pounds, plus or minus five percent. The 09/08/2025 Physician #9 progress note documented the resident' s weights were trending down, and they received a regular diet. The plan was continue to monitor. The 09/11/2025 Registered Dietitian #11 weight change progress note documented the resident weighed 159.9 pounds and had a significant weight loss of 7.6% in three months. The resident's estimated nutritional needs were 1363 calories per day, and 73 grams of protein based on the current weight. Resident #101 had lower extremity edema and was on diuretic medications to help remove the edema. Intake had decreased to 52% and the nutrition diagnosis documented the weight loss was unintended and caused by dementia and decreased intake. Food preferences were updated, and chocolate Ensure was added to the supper meal. Weights were to be monitored and continued monthly. The 11/18/2025 Diet Technician #10 progress note documented the resident had decreased meal intake, assistance and supervision was needed at meals, the resident weighed 157.6 pounds, and no changes were needed at that time. There was no documented evidence of a comprehensive nutritional assessment and more frequent weights after 09/11/2025 when the resident continued to lose weight. The 01/05/2026 Physician #9 note documented Resident #101 was declining, had decreased intake, and weight loss. Monthly weights were noted. The 01/24/2026 Diet Technician #10 progress note documented a weight of 147.6 pounds with a significant weight loss in 6 months. Ensure was added to breakfast and fortified potatoes to lunch. The resident was changed to weekly weights. During an observation on 01/27/2026 at 8:26 AM, Resident #101 was in their bedroom eating breakfast with an occupational therapist. They only ate bites of their solids but consumed most of their beverages, including Ensure. During an interview on 01/27/2026 at 10:22 AM, Diet Technician #10 stated nursing entered the weights in the electronic medical record. They reviewed the weights and made a list of necessary reweights and weekly weights for nursing every Monday. Weights were obtained weekly for four weeks and then monthly unless nutrition requested weekly weights. They checked intake on quarterly assessments unless notified by nursing or observation. If a resident had significant weight loss, they requested a weight to confirm, then would put an intervention in place and notified the medical provider. Significant weight (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loss was a significant concern and could imply other medical issues. They documented on 01/24/2026 when they were alerted about the weight loss, implemented interventions, and changed the resident to weekly weights. During an interview on 01/27/2026 at 10:59 AM, Registered Dietitian #11 stated they documented on all significant weight loss and followed up at least monthly and as needed. They observed for decline in intake at meals and received information in morning report as well. They tracked residents with weight loss weekly until they were stable. The weights were obtained in the first week of the month and then nutrition requested reweights and made a list of weekly weights. Nursing recorded all the weights in the electronic medical record. If a resident had confirmed significant weight loss, they would complete a weight change form to assess for necessary inventions and notify the provider. Weight loss was a significant concern in the elderly because it could imply a medical decline or issue. Resident #101 had new significant weight loss this week and intake was 52%. They were unaware of any weight loss prior to this week, and no new interventions were in place since 09/11/2025 until this week. During an interview on 01/27/2026 at 12:29 PM, Registered Nurse #13 stated if a resident did not eat at meals the staff offered something else to eat, documented the intake and notified them. They would alert the interdisciplinary team in morning report and called nutrition staff. Residents were on monthly weights unless they were being watched closer. Nutrition would tell them if they needed a reweight or weekly weights by adding the resident to the weight list in the nursing station. Nutrition staff were not really in the dining room to observe so they were called with issues. Resident #101 started to have a declining intake and was losing weight. They started keeping the resident on the floor for meals this week, to provide more assistance, and occupational therapy was working with them to increase self-feeding. The resident was eating in the main dining room prior to this week. 10 New York Codes, Rules and Regulations 415.12(i)1