STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335794	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oneida Center for Rehabilitation and Nursing	1445 Kemble Street Utica, NY 13501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the providers wrote, signed, and dated their progress notes at each visit for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Nurse Practitioner #4 initiated and completed a federally mandated visit on Resident #1 including a physical assessment, after Resident #1 was discharged to the hospital and did not return to the facility. Findings include:The 10/2025 facility policy, Physician Documentation, revised 04/26/2023, documented at the time of each physician's visit; a progress notes shall be written, signed, and dated in the physical chart or electronic medical record. The physician shall document in accordance with accepted professional standards of practice, and current Federal and State Regulations. Physician documentation shall be complete and accurately reflect the resident's status throughout the length of their stay. The 03/25/2026 Provider Note by Nurse Practitioner #4 documented Resident #1's blood pressure was completed on 03/25/2026 at 5:48 AM, and their oxygen saturation was completed on 03/25/2026 at 8:11 AM. There was a completed physical assessment of Resident #1 documented. The document was signed by Nurse Practitioner #4 on 03/28/2026 at 5:50 PM. The 03/26/2026 at 1:43 AM, Nursing Note by Licensed Practical Nurse #5 documented Resident #1 had a change in condition with delirium behaviors and was sent to the hospital for evaluation. Vitals were started on Resident #1 at 1:38 AM on 03/26/2026. The 03/26/2026 Provider Note by Nurse Practitioner #4 documented Resident #1 was seen for a federally mandated visit on 03/26/2026. They documented Resident #1 had multiple comorbidities, behaviors were stable, and completed a physical assessment. The included assessment vitals were completed on 03/26/2026 at 1:38 AM and 1:39 AM (the same vitals from the change in condition nursing note on 03/26/2026 at 1:43 AM). The assessment documented Resident #1 was sitting up in their chair, awake, pleasant, and cooperative. They had a clear pharynx (throat), moist mucus membranes, bilateral peripheral pulses were palpable, bowel sounds were present, compression wraps were on the left lower leg, they were alert and in no acute distress, their lungs were clear, they were wearing oxygen, and the provider could heart their heart rhythm. The document was signed by Nurse Practitioner #4 on 03/31/2026 at 4:18 PM. During an interview on 04/29/2026 at 12:18 PM, Licensed Practical Nurse #6 stated the providers were only in the building from 8:00 AM to 6:00 PM, and were on call until 7:00 PM. Nurse Practitioner #4 only worked Tuesdays and Thursday. The provider notes auto-generate in the resident's charts for midnight, but there was a time change thing that happened, so it shows up in the chart as 1:00 AM no matter what time they are started the visit note. The provider has to manual change the time, and most of the providers did not change the time stamp. The visit note pulls the vitals, medications, and diagnoses into the note for the providers to review and edit if need be. The note will pull the most recent vitals taken. If the vitals from the change of condition were in the provider note, then the provider note was started afterwards. During an interview on 04/29/2026 at 1:41 PM, Nurse Practitioner #4 stated they worked varying hours in the facility, but on the day shift. They were currently covering for another provider that was out on leave, and this facility was not their primary facility. Routine visits were scheduled during the day. They stated Resident #1 had a (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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	federally mandated visit due on 03/25/2026, They stated they visited Resident #1 on 03/25/2026 which was supposed to be a discharge visit to go home. They wrote in their notebook that Resident #1 went to the hospital on [DATE] and accidentally put in the wrong date. When asked about the 03/25/2026 visit note for the follow up for pain, Nurse Practitioner #4 stated that the follow up for pain visit on 03/25/2026 and the visit note for 03/26/2026 should have been combined. They stated they were reviewing the records as the facility told them the state was reviewing cases. They noted the mistake and already corrected it. They were not familiar with the facility electronic medical record system, as it was not the same as their primary facility. They did not see the resident on 03/26/2026. They did not always sign off their visit notes on the same day as the visit. They had a lot going on between the two facilities, and things in their personal life, that they were not able to complete and sign off the visits on the same day. During an interview on 04/29/2026 at 2:10 PM, the Administrator stated they did not have audits for the timeliness of provider documentation and completions of notes. They tracked the 30-60-90 federally mandated visits and when they were needed but did not track when the visits were completed and signed off by the providers. The facility had just got a new medical director and had a covering nurse practitioner. They stated that a mandated visit should not be completed on a resident that was sent to the hospital, and not in the facility. During an interview on 04/29/2026 at 2:20 PM, the Director of Nursing stated that if the vitals were in the provider note, that meant the note was opened after the vitals were taken. The system pulls the last set of vitals when generating the document. If the provider created the visit note for that day, the vitals would automatically generate. So, if the vitals in the note were from the change in condition for Resident #1, the note would have been created after the resident went to the hospital. During a telephone interview on 05/06/2026 at 5:26 PM, the Medical Director stated providers had three days to complete their documentation. The complete review of their note and plan of care requirements should be done in that three day window, including locking and signing the note. It was not appropriate to take longer than three days to sign a provider note. The provider notes opened as a template and the information in the note was pulled from the resident's chart automatically. They reviewed the template and could make changes manually, if they wanted. If vitals were in the note that meant the note was started after the vitals were taken. It was not appropriate to have a provider note with a physical assessment included if the resident was no longer in the building. A mandatory visit note would not be required based on the federal requirements once the resident went to the hospital, the timeline would start again on their return. If the provider felt they needed to address the mandatory visit to stay current with the requirements the note should only include, the resident went to the hospital and when, no physical assessment. 10 New York Codes, Rules and Regulations 415(b)(2)(iii)