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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49448 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. Findings include: 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. 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. 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. 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. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. The 2/18/2024 Physician orders documented Juven oral packet, mix with 240 milliliters liquid twice a day for wound healing. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Skin/Wound progress notes by Assistant Director of Nursing #4 documented: - 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. - 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. The following observations were made: - 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. - 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 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. The April 2024 Treatment Administration Record documented the air mattress function was checked: - on 4/9/2024 day shift by licensed practical nurse #11; and evening and night shift by licensed practical nurse #10. - on 4/10/2024 day shift by licensed practical nurse #9; evening and night shift by licensed practical nurse #10. - on 4/11/2024 day shift by licensed practical nurse #8 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. 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. (continued on next page)

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