

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335794	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Oneida Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052</p> <p>Based on record review and interviews during the recertification and abbreviated (NY00326659) surveys conducted on 12/3/2024-12/10/2024, the facility did not provide specific services outside the facility when the facility did not employ a qualified professional to furnish the specific service for 1 of 2 residents (Resident #100) reviewed. Specifically, Resident #100 was referred to neurosurgery and pulmonology (lung specialist) and the facility did not follow up on these referrals in a timely manner.</p> <p>Findings include:</p> <p>The facility policy, Physicians-Consultations, revised 8/2019, documented the facility would ensure all residents received medical care in a timely manner. The attending physician would indicate the appropriate time frame within which the specialist would see the resident. A follow-up appointment was to be done within the time frame requested by the consultant and approved by the attending physician. The attending physician would consider the appropriateness of the consultant's recommendation and the provider approved orders based on consult recommendations if they were appropriate.</p> <p>Resident #100 had diagnoses including pulmonary toxoplasmosis (a serious lung infection), acute respiratory failure, and cerebral edema (swelling of the brain). The 11/4/2024 Minimum Data Set assessment documented the resident had severely impaired cognitive skills for daily decision making, was dependent for activities of daily living, had an active infection of pneumonia, and was on an antibiotic.</p> <p>The 5/1/2024 Comprehensive Care Plan documented the resident had an alteration in their respiratory system. Interventions included to use the incentive spirometry as ordered.</p> <p>The 9/17/2024 consult from an outside brain and spine clinic documented there was a concern for worsening hydrocephalus (spinal fluid buildup in the ventricles of the brain). The plan was to repeat magnetic resonance imaging of the brain to monitor; also concern for pneumonia given new productive cough. The plan was to refer the resident to neurosurgery clinic for a higher level of care as the resident was not an optimal surgical candidate. The consult was illegibly signed by a facility nurse. The medical provider review by the facility was blank and the section to check if new orders were obtained was not checked.</p> <p>(continued on next page)</p>

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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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 9/18/2024 Nurse Practitioner #15 progress note documented the resident had a diagnosis of cerebral edema and went to a neurologist appointment. The neurologist felt the resident needed a higher level of care, a repeat magnetic resonance imaging and a referral was made by that office.</p> <p>The 9/20/2024 Nurse Practitioner #15 progress note documented resident was seen by the spine and brain clinic who recommended a referral to neurosurgery for monitoring of the resident's hydrocephalus.</p> <p>The resident was hospitalized [DATE]-[DATE] for bacterial pneumonia.</p> <p>The 10/2/2024 hospital discharge summary documented the resident was to have outpatient follow ups with pulmonology in one week, neurology in 1 week, and neurosurgery in 1 week. The After Visit Summary Instructions documented follow up with pulmonology in 1 week, neurology in 1 week, and neurosurgery in 1 week. There was a handwritten note documenting all orders in, a smiley face, and me.</p> <p>A 10/2/2024 at 9:11 PM Licensed Practical Nurse #41 progress note, cosigned by Registered Nurse Supervisor #43 documented the resident was readmitted to the facility from the hospital. There was no documented evidence of follow up on the discharge recommendations for pulmonology and neurosurgery.</p> <p>There was no documented evidence the facility scheduled follow up appointments with pulmonology or neurosurgery as recommended.</p> <p>During an interview on 12/4/2024 at 9:02 AM, Resident #100's significant other stated they had issues getting in touch with staff in charge of transportation. They stated the resident missed appointments with their brain and spine doctor as well as a follow up on a magnetic resonance imaging. They stated the resident had fluid on the brain and was supposed to have follow ups.</p> <p>During an interview on 12/06/2024 at 1:16 PM, Medical Records Staff #16 stated they took care of the transportation for resident appointments. They stated they worked with the Nurse Managers to schedule appointments as well. They were mainly responsible for reaching out to the outside providers to schedule appointments, however if a Nurse Manager scheduled an appointment, there was a form they filled out for transportation to be scheduled. They stated they were unaware the resident had a referral pending for neurosurgery and had not been followed up. They stated they were aware of the pulmonology referral from the resident's hospitalization on [DATE]. They attempted to get an appointment scheduled but was having trouble with the office accepting the appointment. They faxed the discharge summary to the office about a week after the resident had returned from the hospital in 10/2024 but they had not followed up since. They stated their procedure was to inform the Nurse Managers if they had issues with scheduling resident appointments. They did let the Nurse Manager know they had trouble scheduling the appointment.</p> <p>During an interview on 12/06/2024 at 1:28 PM, Corporate Resource Nurse (acting Unit Manager) #4 stated there had been a lot of turn over for Nurse Managers on the third floor. They stated they were unaware of the referral for neurosurgery for a higher level of care but that it was normally the spine and brain clinic that would make the referral. They had not heard anything about the referral. They stated they were unaware of there being difficulties with scheduling the resident's pulmonology appointment. They would have advised Medical Records staff #16 to try another office.</p> <p>(continued on next page)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/09/2024 at 3:01 PM, the Director of Nursing stated they expected an outside consult would be followed up in the time frame directed by the office. They stated if a consult had been ordered or referred on 9/17/2024, the facility should have followed up on the referral by now. If there was an issue with scheduling a follow up, they expected the Nurse Managers and the medical providers be made aware.</p> <p>10NYCRR 415.26(e)</p>		