STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335204	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurelia Osborn Fox Memorial Hospital	One Norton Avenue Oneonta, NY 13820

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48615 Based on observation, record review and interviews during an abbreviated survey (Case #NY00297324 and NY00311039), the facility did not ensure residents were free from neglect for 2 (Resident #1 and #2) of 2 residents reviewed for neglect. Specifically, Resident #1, who required two staff to transfer via mechanical lift, was injured when Certified Nursing Aide # 3 transferred Resident #1 by themselves. Additionally Resident #2, who was care planned for having a chair alarm, sustained injury when they attempted to transfer themselves and no chair alarm was present. This is evidenced by: The facility Abuse Prohibition policy and procedure revised 12/31/2021 documented all nursing home residents had the right to be free from verbal, physical, sexual, and mental abuse. All claims of abuse, neglect or mistreatment must be investigated. The facility Mechanical Lift policy and procedure revised 11/19/2021 documented all mechanical lifts required two-person assist. Resident #1 Resident #1 was admitted to the facility with diagnoses of venous insufficiency (when leg veins become damaged and struggle to send blood back up to the heart), age-related osteoporosis (weakening of bones), and shortness of breath unspecified. The Minimum Data Set (an assessment tool) dated 12/13/2023, documented the resident could be understood, could understand others, and was cognitively intact. Comprehensive Care Plan titled, Activities of Daily Living, revised on 2/05/2022, documented Resident #1 required two staff-person assist with mechanical lift using medium-sized sling. Resident Care Kardex (resident care card) dated 3/04/2021 documented Resident #1 was two-person-assist with transfers. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Investigative Report dated 6/12/2022 documented Certified Nurse Aide #3 transferred Resident #1 via mechanical lift without assistance from another caregiver. Resident #1 was care planned as a 2-person assist transfer. Resident #1 complained of pain to groin area during transfer that lined up with straps from mechanical lift pad. Registered Nurse assessment identified 5 centimeter by 5 centimeter bruising to right groin. Certified Nurse Aide #3 admitted to transferring resident independently. Certified Nurse Aide #3 stated they were unable to locate a second caregiver. They acknowledged understanding that Resident #1 was a two-person assist transfer per care plan. Certified Nurse Aide #3 did not know why they failed to approach the nurse for assistance. Nursing progress note dated 6/11/2022 documented Resident #1 complained of swollen area on right inner thigh with bruising noted. Resident #1 stated it occurred during transfer when mechanical lift sling pushed into their leg. During an interview on 3/06/2024 at 2:00 PM, Resident #1 stated they had a bruise on their right thigh after the transfer. During an interview on 3/07/2024 at 10:40 AM, Director of Nursing #1 stated they interviewed Resident #1, who stated they received a bruise from mechanical lift transfer on 6/11/2022. Director of Nursing #1 further stated that Resident #1 indicated Certified Nurse Aide #3 did the transfer alone. Director of Nursing #1 interviewed Certified Nurse Aide #3, who stated they were in a rush to get the resident up and did not get help with mechanical lift transfer They stated training on mechanical lift transfer was given upon hire and annually; and abuse and neglect training was given upon hire, annually and when there was an allegation of abuse or neglect. Resident #2 Resident #2 was admitted to the facility with diagnoses of morbid obesity; epilepsy (a seizure disorder), and polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body). The Minimum Data dated 1/28/2023, documented the resident could be understood and could understand others. Resident # 2 was cognitively intact. The Comprehensive care Plan titled, Falls Risk, dated 11/07/2022, documented use of a chair alarm for Resident #2 at all times. The facility Incident Report dated 2/16/2023 documented, Resident #2 was found on the floor with abrasion to left knee 0.5 centimeters by 0.8 centimeters, a pink area on top of head, left cheekbone with pinkish 3 centimeters by 2 centimeters area and 1 centimeter by 1 centimeter light purple bruise to left bridge of nose towards left eye from glasses nose piece. Resident #2 stated they wanted to transfer from straight back chair to recliner. Resident #2's Care Kardex documented chair alarm to be placed on resident at all times. Certified Nurse Aide #2 stated they forgot to place chair alarm on the resident after caring for them. The Facility Investigative Report dated 2/20/2023 documented Resident #2's chair alarm was not placed on the resident, and resident sustained injury during fall. Certified Nurse Aide #2 admitted to failing to place chair alarm on resident's wheelchair. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/08/2024 10:54 AM, Certified Nurse Aide #2 stated they worked until 7:00 PM on 2/16/2023, sat the resident in their chair and forgot to put chair alarm on them. After they left the room, Resident #2 stood and fell to floor. During an interview on 3/08/2024 at 11:40 AM, Director of Nursing #1 stated Certified Nursing Aide #2 had worked a double shift on 2/16/2023 and was re-educated on reading Resident Care Card and Resident safety. 10 New York Codes, Rules, and Regulations 415.4 (b)(1)(i)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on record review and interviews during an abbreviated survey (Case # NY00304461), the facility did not ensure residents were free from any significant medication errors for 2 (Resident #'s 5 and 6) of 3 residents reviewed for significant medication errors. Specifically, Resident #'s 5 did not receive their Synthroid on 3/27/2022, and Resident #6 did not receive Aspercreme patch applied on 10/27/2022 as ordered. This is evidenced by: The Policy and Procedure titled, Medication Administration Documentation, revised on 5/2023, documented omission of medications was unacceptable except in the case of resident refusal, or when warranted by resident condition. Resident #5 Resident #5 was admitted to the facility with diagnosis of mild cognitive impairment; hypothyroidism (the thyroid gland does not make enough thyroid hormone), and chronic venous insufficiency (leg veins do not allow blood to flow back up to your heart). The Minimum Data Set (an assessment tool) dated 8/17/2022, documented the resident could be understood and could understand others with a Brief Interview of Mental Status indicating moderate impairment. The Medication Administration Record documented Resident #5 had an active order initiated on 10/26/2022, for levothyroxine (Synthroid) 50 microgram tablet. 1 tablet by mouth once daily before breakfast. On 10/27/2022 the medication was signed given by Licensed Practical Nurse #1. Resident #5 was originally prescribed 75 micrograms Synthroid. On 10/26/2022 dosing of Synthroid was decreased to 50 micrograms. During the facility investigation on 10/27/2022, Synthroid 50 micrograms was found in the sharps container. Synthroid 75 micrograms was not removed popped from the blister pack. During an interview on 3/07/2024 at 11:30 AM, Resident #5 stated some mornings they did not receive their 5:00 AM Synthroid medication. Resident #6 Resident #6 was admitted to the facility with diagnosis of Cerebral Palsy (a group of conditions that affect movement and posture), essential hypertension (high blood pressure), and osteoarthritis of both hips. The Minimum Data Set, dated dated dated [DATE], documented the resident could be understood and could understand others and was cognitively intact. The Medication Administration Record dated 3/27/2022, documented Resident #6 had an active order initiated 4/25/2021, for Aspercreme (lidocaine HCL) 4% topical patch. Apply 1 patch by topical route once daily to left groin area, 12 hours on and 12 hours off. On 10/27/2022 the Aspercreme (lidocaine HCL) 4% topical patch was signed given by Licensed Practical Nurse #1. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Investigative Report dated 11/02/2022, documented Resident #6 reported they did not receive their Aspercreme patch on 10/27/2022. Undated skin assessment revealed there was no Aspercreme patch on Resident #6. Aspercreme patch count was the same before and after alleged administration for which Licensed Practical Nurse #1 signed for the medication administration. Resident #6 stated they usually received their medicine but sometimes on overnights they did not receive their Aspercreme patch. Resident #6 stated when they did not receive their pills, they had back pain and felt shaky. During an interview on 3/07/2024 at 2:15PM Licensed Practical Nurse #2 stated Resident #5 had not informed them [Licensed Practical Nurse #2] that they did not receive their medication. During an interview on 3/08/2024 at 11:42 AM, Director of Nursing #1 stated the plan of correction was discontinued May 2023 as it was not doable. They continued to monitor alert and oriented residents that medications were being administered as ordered. During the investigation on 10/27/2022, Synthroid 50 micrograms was found in the sharps container and Synthroid 75 micrograms was not popped from the blister pack. 10 New York Codes, Rules, and Regulations 415.12(m)(2)