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	04/22/2025

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview conducted during a recertification and complaint (Case # NY00345612) survey from [DATE] to [DATE], the facility failed to ensure residents were free from neglect for one (1) (Resident #109) of 23 residents reviewed. Specifically, Resident #109 was assessed by physical therapy on [DATE] as having total dependence on staff and required maximum assistance of two (2) staff members for bed mobility. As a result of the facility's lack of communication for updating the care plan to incorporate the physical therapy assessment, Resident #109 rolled out of bed and suffered a fractured (broken) hip while receiving care from one (1) staff member on [DATE] at 5:05 PM. The failure to provide required staff services and oversight to meet the resident's needs resulted in actual harm to Resident #109 that was not Immediate Jeopardy. This is evidenced by: The facility's policy and procedure titled, Resident Abuse Reporting, last revised [DATE] and last reviewed [DATE], documented the following: • All nursing home residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion and misappropriation of resident property. All reports of resident abuse, neglect and injuries of an unknown origin shall be promptly and thoroughly investigated by facility management. 'Neglect' means failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care to a Nursing Home resident. These services include nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living. The failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. (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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(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 - Actual harm Residents Affected - Few	The facility's policy and procedure titled, Comprehensive Care Plans, last reviewed 05/2024, documented the following: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with their rights. Care plans will include measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. Within 14 days of admission, quarterly and with each significant change, the Inter-Disciplinary Care Plan Team will conduct appropriate assessments, including those in the Minimum Data Set, to determine each resident's physical, mental and psychosocial needs. Assessments will identify strengths, weaknesses, preferences, abilities, and needs and take into consideration the resident's wishes and goals. Charge nurses are responsible for noting all resident changes (including medications, treatments and behaviors) on the 24-hour report. A nurse is designated at each interdisciplinary Tier II morning huddle to document pertinent reported changes on the Daily Changes Report for Care Planning Log. Each item noted will be addressed in the individual's care plan as indicated as soon as possible. Resident #109 was admitted to the facility with diagnoses of generalized osteoarthritis (when the cartilage that cushions the ends of bones in the joints gradually wears away), transient ischemic attacks (a short period of symptoms similar to those of a stroke), and repeated falls. The Minimum Data Set (an assessment tool) dated [DATE] documented the resident could understand and be understood by others. The comprehensive care plan titled Activities of Daily Living, last revised [DATE], documented Resident #109 required assistance with Activities of Daily Living task performance as follows: • Effective [DATE], Resident #109 required supervision at mealtime; partial moderate one (1) staff member assist for bed mobility; partial moderate one (1) staff member assist for grooming, bathing and dressing. Partial/moderate one (1) staff member assist for transfers and toileting. Non-ambulatory. Review of an electronic medical record entry titled Physical Therapy Evaluation and Treatment certification period [DATE] to [DATE] documented start of care [DATE] and the following: • The Functional Mobility Assessment revealed the resident required total dependence with assistance of two (2) staff members for bed mobility. • Physical Therapy clinical impressions documented Resident #109 exhibited increased weakness and instability with functional mobility, and a condition of hypotension (low blood pressure), which could further put the resident at risk for falls. • The Treatment Administration Record documented resident requires assistance of two (2) staff members for bed mobility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of an electronic medical record entry titled, Physical Therapy Treatment Encounter, dated [DATE], documented Resident #109 required maximum assistance by two (2) staff members for bed mobility including transitioning from lying on their back to sitting, and for repositioning. There was no documented evidence the resident's care plan was updated to include that the resident required two (2) staff members for bed mobility. Incident and Accident report dated [DATE] at 5:05 PM, documented Certified Nurse Aide #1 stated Resident #109 was falling out of bed when in resident's room. They tried to stop resident from falling and they both went to the floor. Resident landed on their left side. Progress notes dated [DATE] at 5:37 PM written by Resident Nurse #2 documented Certified Nurse Aide #1 was getting Resident #109 out of bed and resident rolled and started to fall. Certified Nurse Aide #1 eased resident to the floor. The facility's Investigation and Summary report dated [DATE], documented the following: • Resident #109 had a fall incident on [DATE] at 5:05 PM when one (1) staff member provided bed repositioning during incontinence care. Specifically, Certified Nurse Aide #1 assisted Resident #109 with incontinence care in bed. The report documented that Certified Nurse Aide #1 rolled Resident #109 toward them, too close to the edge of the bed. This resulted in Resident #109's head hanging over the edge of the bed, and legs and feet over the side of the bed in a 'V' shape. Certified Nurse Aide #1 was unable to place the resident back into their bed, as most of Resident #109's body weight was leaning on Certified Nurse Aide #1. The report documented that Certified Nurse Aide #1 then lost their balance as they tried to lower Resident #109 to the floor, and both landed on the floor; Resident #109 landed on their left side. • Registered Nurse #1 walked by after the incident and heard resident #109 say Ouch. • Registered Nurse #1 notified Registered Nurse #2. • Resident #109 was assessed as having a singular complaint of pain to their right elbow. • Resident #109 reported their pain increased several hours later. The on-call provider was notified. The resident was transferred to the hospital. (continued on next page)

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	335204	A. Building B. Wing	04/22/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A progress note dated [DATE] at 10:35 PM by Registered Nurse #3 documented Resident #109 was observed in process of evening care on left lateral position (lying on their side) and inquired if they were in pain. Resident #109 claimed a sharp pain on their right hip with 10 on scale of 1 to 10, with 10 as the worst pain. Upon palpation (medical examination technique that involves using the hands or fingers to feel and assess the condition of an organ or body part) of the pelvic area, resident was moaning of severe pain. Tylenol was given. Covering provider notified of assessment and ordered to transfer resident to the emergency room for further evaluation and management. The Hospital Discharge summary dated [DATE], documented the following: Resident #109 presented to the hospital after a fall with femoral neck fracture (broken hip), septic shock (infection in the body causing extremely low blood pressure and organ failure), myocardial infarction (heart attack), and respiratory failure (a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide in the blood). After family notification and discussion, Resident #109 was placed on comfort care measures and expired at the hospital. Interviews: During an interview on [DATE] at 3:14 PM, Director of Nursing #1 stated there was no suspicion of abuse or neglect tied to the [DATE] incident. They stated that they conducted a limited investigation and determined that there was no violation of Resident # 109's care plan. They further stated that Resident #109 did not return to the facility after being transferred to the hospital. Director of Nursing #1 stated they did not follow up with staff for training and/or education on falls following the [DATE] incident. During an interview on [DATE] at 11:33 AM, Rehabilitation Director #1 stated Resident #109 was discharged from Physical Therapy on [DATE]. They further stated that at the time of discharge, Resident #109's bed mobility was at a maximum assist requiring two (2) staff members, also known a total dependence. During an interview on [DATE] at 11:45 AM, Director of Nursing #1 stated after physical therapy assessed a resident and updated a resident's treatment plan, they would bring a written document of it to nursing staff. Director of Nursing #1 stated that it was the responsibility of the nurse manager or nursing supervisor to update the resident's care plan. They further stated that the [DATE] Physical Therapy note for Resident #109 was not updated in the care plan to indicate that the resident was a maximum assistance with two (2) staff members for bed mobility. During an interview on [DATE] at 11:30 AM, Director of Nursing #1 stated Physical Therapy was to provide documentation after their assessment of a resident, and the resident's care plan would be updated accordingly. They further stated that all care plans were reviewed and updated quarterly, if needed. 10 New York Codes, Rules, and Regulations 415.4(b)

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	335204	A. Building B. Wing	04/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, record review, and interview during a recertification and abbreviated survey (Case # NY00343395), the facility did not ensure that all allegations of abuse were thoroughly investigated for one (1) (Resident #3) of seven (7) residents reviewed for abuse. Specifically, Certified Nurse Aide #8 reported an allegation of verbal abuse and rough treatment of Resident #3 during care on the evening shift on 5/24/2024, to the evening supervisor. The facility initiated the investigation on 5/24/2024 at 11:00 PM, when informed of the allegation. There was no documented evidence that all staff involved were interviewed before the determination was made that the allegation was inconclusive. This is evidenced by: The facility's policy titled Resident Abuse Reporting revised on 11/29/2021 and last reviewed on 10/24/2024 documented: 1. When there is reasonable cause to suspect resident abuse the responsible individual would immediately be suspended without pay while the investigation is being conducted. 2. All claims of abuse and allegations are thoroughly investigated. The designated Nursing Supervisor initiates investigation and notifies the Director of Nursing. 3. Identify the following: a. Name of person or persons suspected of abuse, b. Mistreatment or neglect, name of the resident, c. Name of witnesses, d. Date, time and place incident occurred e. Nature and extent of abuse, mistreatment or neglect 4. Notify the Administrator as appropriate 5. All relevant staff who may have information about the abuse allegations would be obtained from all witnesses, to include an accurate description of the occurrences. These would be signed and dated. These statements will be kept confidential and will be provided to the investigator from the New York State Department of Health/Attorney General's Office, et al. If there are any staff who are not interviewed the facility must document, why that staff was not interviewed. (continued on next page)

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	335204	A. Building B. Wing	04/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Interviewers questions should be documented. Resident #3 was admitted to the facility with diagnoses of non- Alzheimer's dementia (condition that occurs with memory loss and cognitive functioning) without behavioral disturbances, hypertension (a condition where the force of your artery walls blood against your artery walls is consistently too high), and depression (a persistent feeling of sadness and loss of interest or pleasure in the activities of daily living). The Minimum Data Set (an assessment tool) dated 3/06/2025, documented the resident was sometimes understood and could sometimes understand others with severely impaired cognition for daily decision making. An ACTS (Aspen Complaints Tracking System) complaint/incident report date 5/28/2024 documented that a complaint was submitted to the New York State Reporting division on 5/25/2024 at 2:01 AM, that alleged Resident #3 had been verbally abused with rough handling during care on 5/24/2024 during the 3:00 PM to 11:00 PM shift by Certified Nurse Aide #9. The facility investigation and summary dated 5/29/2024 documented a log of 9 witnesses were listed on the investigation that were working the night the incident occurred on 5/24/2024 on the 3 to 11 PM evening shift. Certified Nurse Aide #8 was orienting Certified Nurse Aide #9, and they were providing care for Resident #3 preparing the resident for bed. Certified Nurse Aide #8 reported to the Licensed Practical Nurse #4 at the end of the shift that Certified Nurse Aide #9 had handled Resident #3 roughly during care and used foul language during transferring the resident and said they had them leave the room and looked at the residents back to see if there was any injury and found none. Certified Nurse Aide #9 stated they had hurt their back and left the building before Certified Nurse #8 reported the incident. The incident was reported to the Registered Nurse Supervisor #1 who then notified the Director of Nursing. The resident was interviewed by the Registered Nurse Supervisor #1 and a skin assessment was done with no injury found, Resident #3 could not recall the incident and denied psychological harm. Staff was interviewed and reported no care concerns with Certified Nurse Aide #9, who was interviewed and denied allegations. Certified Nurse Aide #9 was suspended at 5/25/2024 at 1:30 AM, pending the outcome of the investigation. The outcome of the investigation was inconclusive because the allegation could not be verified or refuted because there was insufficient information to determine whether the allegation had occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/21/2025 at 11:47 AM, Director of Nursing #1 stated all interviews of staff involved were not completed. Some of the staff interviews were done by phone because the incident was reported to the nurse at the end of the shift and Certified Nurse Aide #9 had already left the building. The investigation was started on 5/24/20/24 at 11:30 PM, and called into the New York State Department of Health reporting bureau as soon as it was reported to the supervisor, who immediately contacted the Director of Nursing #1 within 2 hours of the allegation being reported. The facility was unable to come to a determination that the allegation was substantiated. The resident had no injuries, and they had no witnesses that could collaborate Certified Nurse Aide #8's allegation of abuse by other staff or residents. Certified Nurse Aide #9 was suspended until the outcome of the allegation was investigated. Certified Nurse Aide #9 never returned to the facility and accused staff of behaving unprofessional in front of residents and resigned. A signed letter by Certified Nurse Aide #9 was sent to the facility and allegations of inappropriate language and care around residents was reported to the facility. Director of Nursing stated they followed up with interviews about these allegations but had no written or signed statements by staff when this was done. Some of the staff were no longer employed by the facility. There was reeducation started immediately with abuse and neglect and reporting done by the Registered Nurse Educator #1. Certified Nurse Aide #8 was given a verbal warning and reeducated because they had delayed reporting the incident to the Supervisor. 10 New York Code of Rules and Regulations 415.4(b)(2)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #109 Resident #109 was admitted to the facility with diagnoses of generalized osteoarthritis (when the cartilage that cushions the ends of bones in the joints gradually wears away), transient ischemic attacks (a short period of symptoms similar to those of a stroke), and repeated falls. The Minimum Data Set (an assessment tool) dated 2/09/2024 documented the resident could understand and be understood by others. The comprehensive care plan titled Activities of Daily Living, last revised 4/11/2024, documented Resident #109 required assistance with Activities of Daily Living task performance as follows: Effective 1/08/2024, Resident #109 was a supervision at mealtime; partial moderate one (1) staff member assist for bed mobility; partial moderate one (1) staff member assist for grooming, bathing and dressing. Partial/moderate one (1) staff member assist for transfers and toileting. Non-ambulatory. There was no documented evidence the resident ' s care plan was revised on 3/08/2024, to include the resident required a maximum of two (2) staff members for bed mobility. During an interview on 4/21/2025 at 11:33 AM, Rehabilitation Director #1 stated Resident #109 was discharged from Physical Therapy on 3/08/2024. They further stated that at the time of discharge, Resident #109 ' s bed mobility was at a maximum assist. requiring two (2) staff members, also known a total dependence. During an interview on 4/21/2025 at 11:45 AM, Director of Nursing #1 stated after physical therapy assessed a resident and updated a resident ' s treatment plan, they would bring a written document of it to the nursing staff. Director of Nursing #1 stated that it was the responsibility of the nurse manager, or nursing supervisor, to update the resident ' s care plan. They further stated that the 3/08/2024 Physical Therapy note for Resident #109 was not updated in the care plan to indicate that the resident was a maximum assistant with two (2) staff members for bed mobility. Resident #3 Resident #3 was admitted to the facility with diagnoses of Non-Alzheimer ' s dementia (condition that occurs with memory loss and cognitive functioning) without behavioral disturbances, hypertension (a condition where the force of your artery walls blood against your artery walls is consistently too high), and depression (a persistent feeling of sadness and loss of interest or pleasure in the activities of daily living). The Minimum Data Set, dated [DATE], documented the resident was sometimes understood and could sometimes understand others with severely impaired cognition for daily decision making. A Physicians Order dated 3/2025, documented Resident #3 was to receive Zyprexa (an antipsychotic, a medication ordered to treat mental health conditions) 2.5 milligrams one (1) time a day. (continued on next page)

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	335204	A. Building B. Wing	04/22/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physicians Order dated 4/02/2025, documented Resident #3 was to receive Zyprexa (an antipsychotic, a medication ordered to treat mental health conditions) 1.25 milligram one (1) time a day. An electronic Medication administration record dated March 2025 documented Resident #3 received Zyprexa 2.5 milligrams 1 time a day for 31 days. An electronic Medication administration record dated April 2025 documented Resident #3 received Zyprexa 2.5 milligrams one (1) time a day for one (1) day on 4/01/2025. An electronic Medication administration record dated April 2025 documented Resident #3 received Zyprexa 1.25 milligrams one (1) time a day for 20 days beginning on 4/02/2025 through 4/21/2025. A psychiatric tele health progress note dated 4/02/2025 documented a trial gradual dose reduction was being attempted and the resident ' s antipsychotic medication was being decreased to 1.25 milligrams beginning 4/02/2025. Review of Resident #3 ' s comprehensive care plan for psychotropic medications implemented on 10/16/2023, did not include the gradual dose reduction performed on 4/02/2025, and did not include goals and intervention with signs and symptoms to monitor while the gradual dose reduction was being attempted. During an interview on 4/21/2025 at 11:17 AM, Registered Nurse #6 stated that Resident #6 had been seen by telehealth and had a gradual dose reduction performed. The gradual dose reduction should have been documented in the resident ' s care plan under behaviors or in the psychotropic care plan. Registered Nurse #6 could not provide any evidence that demonstrated documentation had been placed in the resident ' s comprehensive care plan, but it should have been updated when this was done in case the resident had complications with the decrease in the medications. During an interview on 4/22/2025 at 11:30 AM, Director of Nursing #1 stated Physical Therapy was to provide documentation after their assessment of a resident, and the resident ' s care plan would be updated accordingly. They further stated that all care plans were reviewed and updated quarterly, if needed. 10 New York Codes, Rules, and Regulations 415.11(c)(2)(i-iii) The facility ' s policy and procedure titled, Comprehensive Care Plans, last reviewed 05/2024, documented the following: The facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with their rights. Care plans would include measurable objectives and timeframes to meet a resident ' s medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment. Within 14 days of admission, quarterly and with each significant change, the Inter-Disciplinary Care Plan Team would conduct appropriate assessments, including those in the Minimum Data Set, to determine each resident ' s physical, mental and psychosocial needs. Assessments would identify strengths, weaknesses, preferences, abilities, and needs and take into consideration the resident ' s wishes and goals. Charge nurses were responsible for noting all resident changes (including medications, treatments and behaviors) on the 24-hour report. A nurse was designated at each interdisciplinary Tier II morning huddle to document pertinent reported changes on the Daily Changes Report for Care Planning Log. Each item noted would be addressed in the individual ' s care plan as indicated as soon as possible. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and interview conducted during a recertification and abbreviated survey (Case # NY00345612), the facility did not ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for two (2) out of three (3) residents (Resident #s 3 and 109) reviewed for care planning. Specifically, (a.) Resident #109 ' s comprehensive care plans for Activities of Daily Living, Bed Mobility were not revised following Physical Therapy assessment and recommendations on 3/08/2024. Resident #109 was assessed by physical therapy on 3/08/2024 as having total dependence on staff and required maximum assistance of two (2) staff members for bed mobility. As a result of the facility not communicating the physical therapy recommendations, Resident #109 rolled out of bed and suffered a fractured (broken) hip while receiving care from one (1) staff member on 4/28/2024 at 5:05 PM. Specifically: (b.) Resident #3 ' s comprehensive person center care plan for antipsychotics had not been revised with goals and interventions when a gradual dose reduction was performed on 4/02/2025, and the residents Zyprexa was decreased from 2.5 milligrams to 1.25 milligrams daily. This is evidenced by: