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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36922 Based on observations and interviews conducted during a recertification survey, the facility did not ensure each resident was treated with respect and dignity in a manner and environment that promoted maintenance or enhancement of their quality of life for five (5) (Resident #s 21, 31, 32, 64, and 99) of 23 residents reviewed for dignity and respect. Specifically, (a.) Resident #s 31 and 32 had Foley catheters that were fully visible from the hallway, outside resident rooms and in common areas, and not in cover bags; (b.) Resident #64 reported that staff spoke to them 'like they were retarded' and ignored their requests to open the room dividing curtain when their roommate was not in the room; (c.) Resident #99's repeated request to be toileted was ignored by staff while the surveyor was on the resident's unit; and (d.) Resident #21 stated that staff did not provide care in a dignified way, handled them roughly, and that staff would smell of marijuana and cigarettes which the resident found offensive. This is evidenced by: The Policy and Procedure titled, Resident's Rights and Responsibilities, last reviewed May 2012, read that the resident had the right to privacy during medical treatment and care and in personal hygiene matters. The residents have the right to make choices of their life that were significant to them. The facility would meet the resident's individual needs and preferences to the extent possible, and a right to a homelike environment and to use their personal belongings and furnishing to the extent these can be used in accordance with health and safety regulations. A Right to privacy during medical treatment and care and in personal hygiene matters. 48615 (a) Right to meet the resident's individual needs and preferences. Resident #21 was admitted to the facility with the diagnoses of squamous cell carcinoma of skin of scalp and neck (cancer cell that form on the surface of the skin), type 2 diabetes mellitus with diabetic neuropathy (endocrine dysfunction causing issues regulating blood sugar that causes damage to nerves in the legs, feet and hands), and morbid obesity (excessive body fat causing a body mass index of 40 or higher). The Minimum Data Set, dated dated dated [DATE] documented that the resident was able to be understood and understand others, with minimal cognitive impairment. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Care Plan for Compassionate and Personal Caregiving Visitors, dated effective 6/11/2021, documented that Resident #21 would have access to compassionate and personal caregivers as needed. The interventions documented that the resident or sponsor would designate preferences or changes for designated caregivers as desired but at least quarterly. During an interview on 4/15/2025 at 11:24 AM, Resident #21 stated that most of the staff were fine, however there were a few staff that were rough with residents. Resident #21 stated that they had told the administrator about it but nothing was done. Additionally, staff smoked marijuana outside the facility and came into work smelling of marijuana that the resident found very bothersome. During an interview on 4/21/2025 at 12:01 PM, Administrator #1 stated that they had no recall of anyone reporting smelling of marijuana recently but had had an issue of Certified Nurse Aide #4 that was reported for smelling of cigarette smoke but had been educated on staff expectations. Administrator #1 stated that they had received reports of rude and/or inappropriate interactions with some Certified Nurse Aides. Administrator #1 stated that some Certified Nurse Aides had louder voices that might be misconstrued as rude. Additionally, Administrator #1 stated that Resident #21 and Certified Nurse Aide #3 had a personal history outside of the facility and that there had been previous conversations with Certified Nurse Aide #3 regarding their shared history. Administrator #1 stated that any issues were addressed as soon as they were brought to their attention. Resident #99 was admitted to the facility with the diagnoses of unspecified severe dementia with agitation (a progressive degenerative memory disease that can cause severe physical or verbal aggression), type 2 diabetes mellitus without complications (an endocrine dysfunction that causes irregular blood sugar levels), and obstructive sleep apnea (a sleep disorder that causes episodes of complete airway collapse or partial collapse with decrease in oxygen saturation). The Minimum Data Set, dated dated dated [DATE], documented that was sometimes understood and sometimes understand others, with severe cognitive impairment. The Comprehensive Care Plan for Compassionate and Personal Caregiving Visitors, effective 8/09/2024, documented the goal of the resident will have access to compassionate and personal caregivers as needed. The Comprehensive Care Plan for Cognitive impairment/poor judgement/memory loss, effective 8/20/2024, documented the resident would participate in self-care within mental and physical limitations. Interventions documented to encourage self-performance in making decisions and assisting with care needs each day. The Comprehensive Care Plan for Elimination: Urinary Incontinence, effective 8/22/2024, documented the goal of the resident will not experience complications related to incontinence as evidenced by no signs or symptoms of urinary tract infections, skin breakdown or rashes, and utilize prompted voiding every one to two (1-2) hours with positive reinforcement. During an observation on 4/16/2025 at 10:01 AM, Resident #99 was noted to be in the common area of the unit while activities took place in dining room. Resident #99 was observed repeatedly requesting to go to the bathroom. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the time of the observation, Licensed Practical Nurse #6 was made aware that the resident was asking repeatedly to go to the bathroom. Licensed Practical Nurse #6 stated that Resident #99 had just gotten off the commode and that Certified Nurse Aide #11 would get to them. Resident #99 was eventually taken to the bathroom at 10:50 AM, after Certified Nurse Aide #12 came from another unit to assist Certified Nurse Aide #11. 48744 (B) Right to privacy during medical treatment and care and in personal hygiene matters. Resident #31 was admitted to the facility with the diagnoses of morbid obesity (severe form of obesity characterized by a significantly excessive amount of body fat), acquired absence of a leg above the knee (amputation of one leg above the knee joint), and neuromuscular dysfunction of the bladder (condition where the bladder's muscles and nerves don't function properly due to damage to the brain, spinal cord, or nerves that control bladder function). The Minimum Data Set (an assessment tool) dated 2/28/2025, documented the resident usually could be understood, understand others, and was significantly cognitively impaired. Resident #31's Comprehensive Care plan for Elimination related to Foley catheter, dated 7/22/2024 and last reviewed 4/20/2025, documented that the resident would not experience complications related to catheter as evidenced by no signs or symptoms of urinary tract infection or kinked tubing. There was no documented intervention of placing the Foley bag in a cover bag to provide the resident privacy regarding their medical conditions. A Physician order dated 3/07/2025 at 10:45 AM documented that the resident had a Foley catheter to gravity drainage to be changed monthly and as needed. During an observation on 4/15/2025 at 10:43 AM, Resident #31's Foley catheter was visible from the hallway, not covered, hanging from the resident's bed. During an observation on 4/18/2025 at 9:00 AM, Resident #31's Foley catheter was visible from the hallway, not covered, hanging from the resident's bed. Additionally, there was a urine smell emanating from the resident's room. Resident #32 was admitted to the facility with the diagnoses of obesity (disorder that involves having too much body fat), acute gastroenteropathy due to Norwalk agent (a viral infection that causes inflammation of the stomach and intestines, leading to symptoms like vomiting, stomach cramps, and fever), and neuromuscular dysfunction of the bladder (condition where the bladder's muscles and nerves don't function properly due to damage to the brain, spinal cord, or nerves that control bladder function). The Minimum Data Set, dated dated dated [DATE], documented the resident was able to understand others, able to make themselves understood, and was cognitively intact. Resident #32's comprehensive care plan for Foley catheter dated 2/19/2024 and last reviewed 5/23/2025, documented that the resident would maintain clear yellow urine via Foley catheter and will have no urinary tract infection during the review period. There was no documented intervention of placing the Foley bag in a cover bag to provide the resident privacy regarding their medical conditions. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician order dated 3/11/2025 at 10:49 AM documented that the resident had a Foley catheter to gravity drainage to be changed monthly and as needed. During an observation on 4/16/2025 at 9:58 AM, Resident #32's Foley catheter was visible from the hallway, not covered, hanging from the resident's bed. During an observation on 4/17/2025 at 11:47 AM, Resident #32's Foley catheter was visible from the hallway, not covered, hanging from the resident's bed. During an observation on 4/18/2025 at 10:41 AM, Resident #32's Foley catheter was visible from the hallway, not covered, hanging from the resident's bed. (c) Right to make choices of their life that were significant to them. Resident #64 was admitted to the facility with the diagnoses of obesity, type 2 diabetes mellitus (an endocrine dysfunction causing irregular blood glucose levels), and obstructive sleep apnea (a condition involving constriction of the airways and difficulty or discomfort in breathing). The Minimum Data Set, dated dated dated [DATE], documented the resident was able to understand others, able to make themselves understood, and was cognitively intact. The Comprehensive Care Plan for environmental check dated 1/15/2025 documented keeping the floor uncluttered, kept dry, bed in lowest position, and that water, food and personal items were kept within reach. There was no documented intervention of keeping the resident's privacy curtain open when Resident #64 was alone in their room. During an interview on 4/16/2025 at 10:33 AM, Resident #64 stated that they felt the staff treated them like they were a retard and that they had requested the staff leave the curtain open when their roommate was not in the room, but the staff refused to answer their request. During an observation on 4/17/2025 at 10:53 AM, Resident #64's call bell was going off. It was not answered until 11:03 AM. At that time, the staff member that entered Resident #64's room stated they would come back. By 11:34 AM, no staff had returned to the room, except one other staff that turned off the resident's light and stated they would be back. Resident #64 stated they had been trying to be changed since 9:30 AM but the staff had not been able to get to them yet. The curtain was observed to be open, and Resident #64 was in the room with their family member. During an observation on 4/21/2025 at 10:58 AM, Resident #64's curtain was open. During an interview on 4/22/2025 at 9:44 AM, Registered Nurse #4 stated that dignity was part of annual education and that Foley should be covered in a blue bag. During an interview on 4/22/2025 at 10:44 AM, Resident Nurse #5 stated that Foley bags should have been covered with a blue bag, or if those were not available a pillowcase could be used, and that Foley should be not visible to the public eye. Registered Nurse #5 had returned from vacation that day and saw that multiple Foley bags were not covered. Registered Nurse #5 could not state why the staff were not following the rules. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2025 at 11:12 AM, Director of Nursing #1 was asked for examples of issues that might arise that would impact resident's feelings of being treated with dignity. Director of Nursing #1 stated that people being covered up so that personal body parts were not visible would be an example. Additionally, knocking on resident's doors before entering would be considered dignified, speaking to the residents in kind and respectful ways, and making sure that Foley catheters were covered and not visible to visitors. 10 New York Codes, Rules, and Regulations 415.5(a)

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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** 48615 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. The facility's policy and procedure titled, Comprehensive Care Plans, last reviewed ,d+[DATE], 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on record review and interviews during the recertification survey, the facility did not ensure that each resident was screened for a mental disorder or intellectual disability prior to admission for three (3) (Resident # ' s 9, 31, and 91) of 23 residents reviewed. Specifically, there was no documentation that a Preadmission Screening and Resident Review (PASARR, New York State Department of Health Form 695) was completed for these three (3) residents by a qualified screener prior to admission to the facility. This is evidenced by: A facility policy titled, Pre-Admission Screening & Resident Review (PASRR) Assessments, effective 9/2005 and last reviewed 7/2023, documented that all residents admitted for placement at the facility who met the requirements of mental disability via the Level 1/Level 2 Screen would have a referral completed to the appropriate agency for a federal per-admission screening and resident review (PASARR). The Purpose documented was to assure residents with diagnoses of mental retardation or mental illness were assessed by the appropriate Preadmission Screening and Resident Review agency to determine if specialized services were indicated. Under General Information, the policy documented that all residents who sought admission to this Skilled Nursing Facility would have a Level 1 Screen completed by the referring agency/hospital. If a resident ' s Level 1 Screen demonstrated a potential need for specialized services, the referring agency/hospital would contact the appropriate agency for a Preadmission Screening and Resident Review to be completed. Resident #9 Resident #9 was admitted to the facility with the diagnoses of bipolar disorder (a mood disorder associated with episodes of mood swings ranging from depressive lows to manic highs), acute respiratory failure with hypoxia (a condition where the lungs fail to adequately oxygenate the blood, leading to a low oxygen level in the blood), and pneumonia (lung inflammation caused by bacterial or viral infection). The Minimum Data Set (an assessment tool) dated 4/01/2025, documented the resident was able to understand others, be understood, and was minimally cognitively impaired. Resident #9 ' s Preadmission Screening and Resident Review, dated 3/12/2025, documented ' No ' for Question #23 that read, ' Does this person have a serious mental illness? ' There was no documented evidence that Resident #9, who had a diagnosis of bipolar disorder, was screened for a serious mental illness. There was no documented evidence that the Preadmission Screening and Resident Review was completed prior to admission to the facility on [DATE]. Resident #31 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #31 was admitted to the facility with the diagnoses of morbid obesity (severe form of obesity characterized by a significantly excessive amount of body fat), adjustment disorder with anxiety (a mental health condition characterized by a strong emotional or behavioral reaction to a stressful event or change in life, specifically involving anxiety as a primary symptom), and depression (a mood disorder characterized by persistent feelings of sadness and loss of interest or pleasure in activities). The Minimum Data Set, dated dated dated [DATE], documented the resident could be understood, was usually understand others, and was significantly cognitively impaired. Resident #31 ' s Preadmission Screening and Resident Review, dated 10/17/2024, documented ' No ' for Question #23 that read, ' Does this person have a serious mental illness? ' There was no documented evidence that that Resident #31, who had a diagnoses of adjustment disorder with anxiety and depression, was screened for a serious mental illness. There was no evidence that the Preadmission Screening and Resident Review was completed prior to admission to the facility on [DATE]. Resident #91 Resident #91 was admitted to the facility with the diagnoses of depression (a mood disorder characterized by persistent feelings of sadness and loss of interest or pleasure in activities), panic disorder (a mental and behavioral disorder, specifically an anxiety disorder characterized by reoccurring unexpected panic attacks), and multiple sclerosis (a chronic, neurological disease that affects the central nervous system, primarily the brain and spinal cord). The Minimum Data Set, dated dated dated [DATE], documented the resident was able to understand others, be understood, and was cognitively intact. There was no evidence that the Preadmission Screening and Resident Review was completed prior to admission to the facility on [DATE]. During an interview on 4/22/2024 at 11:12 AM, Director of Nursing #1 stated that social work reviewed the Preadmission Screening and Resident Review before residents were admitted to the facility. During an interview on 4/22/2024 at 11:35 AM, Director of Social Work #1 stated that Preadmission Screening and Resident Review were filled out prior to admission by the hospital or facility sending the resident. Director of Social Work #1 stated that the dates on the screens could be confusing because a resident might go back and forth from the hospital or go home and come back, causing the admitted s and screen dates look like they did not line up. Additionally, Director of Social Work #1 stated that for a resident to have been considered to have a serious mental illness, they would have had to have inpatient treatment for treatment of the mental illness, or the mental illness would have to be an active issue at the time of the screen. If the resident was not presenting as having psychiatric issues, they would have a screen that would reflect no mental illness. It was not enough just to have a diagnosis of a serious mental illness. Director of Social Worker #1 stated that if the Preadmission Screening and Resident Review no longer matched the psychiatric presentation of the resident, they would complete a new screen. Additionally, Director of Social Work #1 stated that all 3 of the residents with questionable Preadmission Screening and Resident Reviews were being provided psychiatric services either through the facility or had community providers they continued to see and that all 3 residents were appeared stable and had not had any issues. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Code of Rules and Regulations 415.11(3)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36922 Based on record reviews and interviews conducted during the recertification survey, the facility did not ensure the development of comprehensive person-centered care plans, that included measurable objectives and time frames to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for one (1) (Resident #72) of 23 residents reviewed for comprehensive care plans. Specifically, for Resident #72, comprehensive care plan was not developed to address the resident's medical issues requiring medications. This is evidenced by: The facility policy titled, Comprehensive Care Plans, last reviewed date 5/2024, documented the purpose to meet each resident's preference and goals, and address each resident's medical, physical, mental, and psychosocial needs. Under Procedures, documented routine data was collected, e.g. physical signs and symptoms, lab values, resident history, medications, activities of daily living, preferences and resident goals from the time of admission. 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 changed 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. The date completed was noted on the log. Non-nursing departments were likewise responsible for noting non-significant, but pertinent changes would be noted on the care plan with the indicated problem, goal and/or approach changes at the time such were noted. 48744 Resident #72 was admitted to the facility with the diagnoses of unspecified dementia, moderate, with agitation, anxiety disorder (a mental condition characterized by excessive fear or apprehension about real or perceived threats), and functional intestinal disorder, unspecified (a group of conditions where the digestive tract does not operate properly). The Minimum Data Set, dated dated [DATE] documented resident had severe cognitive impairment, could be usually understood, and understand others. Resident #72's Comprehensive Care Plan for Psychotropic Drug Use: Anxiety State/Dementia, dated 6/29/2023, documented the resident was taking Seroquel. The goal listed was resident would not experience negative side effects from psychotropic med use. The interventions documented monitor for side effects of medication such as: No documented side effects were listed in the comprehensive care plan. The Physician Order dated 3/22/2025 at 10:14 AM, documented Seroquel 25 milligram tablet, give 0.5 tablet (12.5 milligrams) by oral route once daily at bedtime for unspecified dementia, moderate, with agitation, daily at 9:00 PM. The original order date was noted to be 1/31/2025, and the resident had a gradual dose reduction completed, lowering the dose from 25 milligrams to 12.5 milligrams. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2025 at 10:07 AM, Registered Nurse #5stated that care planning was lacking because they did not have enough time in the day to take care of all the resident's needs on the unit, and review or revise resident care plans. They stated that they did the best that they could and that Register Nurse #5did a lot of the care plan paperwork. Registered Nurse #5 did not have an answer as to why no side effects were listed on the comprehensive care plan. During an Interview on 4/22/2025 at 11:22 AM, Director of Nursing #1 stated that Registered Nurse #7 worked mostly remote and did a lot of the work on care plans. All facility Registered Nurses were responsible for updating care plans, but Registered Nurse #7 did mostly the initial care plans, and some updating. In specific regards to Resident #71's care plan, Director of Nursing #1 stated that the side effects should have been listed. 10 New York Codes, Rules and Regulations 415.11(c)(1)

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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** 36922 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: 48615 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. 48744 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 dated 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. 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 48615 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for one (1) (Resident #35) of 3 residents reviewed. Specifically, Residents #35, was not provided with any meaningful, accommodating activities to maintain their highest quality of life. This is evidenced by: The facility's Policy and Procedure Titled Activities Department Policy, revised 12/2024, documented it's policy is: To help residents maintain their optimal level of physical, mental, psychosocial, spiritual, and emotional functioning and independence. Facility promotes individual achievements, self-expression, creativeness, recognition, security, growth through diversified activities, to assist in developing social relationships, a sense of usefulness, a sense of pride in accomplishments, and a sense of self-respect. The Activities Department would document progress every 90 days, indicating participation in activity programs. Provide materials and supplies for residents based on their needs and interests. Offer appropriate accommodations for each resident based on their sensory requirements. Provide 1:1 visit offer large/small group activities to socially engage, cognitively/sensory stimulate, comfort, educate, and offer physical activity depending on residents needs and likes. Resident #35 was admitted to the facility with diagnoses of macular degeneration (a disease that affects a person's central vision); legally blind; and polyneuropathy (multiple nerves become damaged). The Minimum Data Set (an assessment tool) dated 3/22/2025, documented resident had intact cognition, could be understood, and understand others. The Patient Centered Comprehensive Care Plan titled, Focus Activity dated 1/22/20255 documented, Resident is alert/oriented and makes their needs known regarding activity involvement. Resident has no interest in attending group activities at this time. Resident does have independent activities of interest and notes their husband visits daily. Resident does have bilateral hearing deficit and utilizes bilateral hearing aids. Resident is legally blind. Resident requires occasional invitations to see if their interest in attending group activities changes. Resident would maintain independent activities that were enjoyable and interest them daily. Resident would express satisfaction with supplies for independent activities and level of socialization. Interventions: Offer materials to aid in intended activities of interest: (TV channel guide, large print, magnifier, audiobooks). During an observation on 4/14/2025 at 01:29 PM, Resident #35 was sitting in recliner with feet elevated in their room. Resident was able to engage in conversation with surveyor. Resident's hearing was adequate. There were no assistive devices noted in room. During an interview on 4/14/2025 at 1:29 PM, Resident #35 stated they did not really come out of their room due to poor vision. They preferred to stay in their room. Resident #35 stated they could only see a few things likes shapes and colors. They love to read but no longer could read due to macular degeneration. Resident stated they had no adaptive devices. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/2025 at 10:04 AM, Director of Activities #1 stated Resident #35 preferred to stay in their room, they did not want to attend group activities. Resident #35 liked to do things in their room, such as watch television or listen to music. Upon admission, Resident #35 was assessed for social preferences and needs. They were offered audio books in January of 2025 and declined. Since then, they had not been offered any other audio books. There were no documented 1:1 visit. During an interview on 4/18/2025 at 10:36 AM, Social Worker #1 stated residents who were hearing and visually impaired were assessed by Speech and Language Therapy. Communication Boards and visual aids were provided as need by therapy. Resident #35 had no visual aids or accommodations. Social Worker #1 stated Resident #35's sister-in-law visited daily and they were hoping to have Resident #35 move into the same room as their husband who is also a resident at the facility. During an interview on 04/18/2025 at 10:30 AM, Resident #35 stated they would very much like to listen to audio books but thought they might be expensive. They stated if there were no cost, they would really like to listen to audio books. During an observation on 4/21/2025 at 10:00AM, Resident #35 was noted to have audio book playing in their room. Resident #35 stated they were very appreciative, and looking forward to doing this daily. 10 New York Codes, Rules, and Regulations 415.5(f)(1)h

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, residents were not assisted with care when requested, staff complained of not able to complete all the required tasks assigned and provide resident care, and the staffing sheets provided while on site did not accurately reflect the needs of the facility population. This is evidenced by: Facility Assessment The facility assessment dated ,d+[DATE] documented that the staffing plan was based on the resident population and their needs for care and support. The staffing plan documented the following daily staffing needs: Average daily census: 103 (Unit 1 with 1-24 residents, Unit 2 with 2-45 residents, Unit 3 with 3-34 residents). The total facility's certified beds numbered 130, with one respite bed (Unit 1 with 1-40, Unit 2 with 2-46, Unit 3 with 3-45). Per shift, per unit, the number of minimum staff required were as follows: Days: Unit 1 required 1 nurse and 2 Certified Nurse Aides; Unit 2 required 2 nurses and 4 Certified Nurse Aides; Unit 3 required 2 nurses and 3 Certified Nurse Aides. Evenings: Unit 1 required 1 nurse and 2 Certified Nurse Aides; Unit 2 required 1.3 nurses and 4 Certified Nurse Aides; Unit 3 required 1.3 nurses and 3 Certified Nurse Aides. Nights: Unit 1 required 1 nurse and 1 Certified Nurse Aide; Unit 2 required 1 nurse and 2 Certified Nurse Aides; Unit 3 required 1 nurse and 2 Certified Nurse Aides. [Note: Where Days = 7:00 AM to 3:00 PM, Evenings = 3:00 PM to 11:00 PM, Nights = 11:00 PM to 7:00 AM] Observations: Upon entrance to the facility on [DATE] there were 108 residents residing on 3 units and at no time was the facility census less than 105 residents in the building. During general observations on 4/14/2025 at 11:00 AM, a strong odor of feces was noted in the hallway near room [ROOM NUMBER]. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During general observations on 4/15/2025 at 9:30 AM, a strong odor of feces was noted in the 100-unit common room. A Licensed Practical Nurse was made aware and stated that they would tell the aide. After twenty minutes, no care had been provided. Director of Nursing #1 was notified, and they sent a Certified Nurse Aide to assist. During an observation on 4/15/2025 at 10:58 AM, the call bell for room [ROOM NUMBER] was noted to have been on for a number of minutes and was not answered until 11:15 AM by a Licensed Practical Nurse who asked the resident in the room what they needed. The resident stated they needed to go to the bathroom. The Licensed Practical Nurse stated they would be right back, turned off the resident's light, went down the hall, turned off the call bell light going off in room [ROOM NUMBER], and then returned to room [ROOM NUMBER] to provide care. During general observations on 4/16/2025 at 10:49 AM, a foul odor was noted in the Unit 2 hallway near room [ROOM NUMBER] and 208. During general observations on 4/17/2025 at 10:34 AM, a strong urine odor was noted throughout the 200-unit hallways. Staffing Sheets: A review of staffing sheets provided by the facility from 4/14/2025 through 4/22/2025 documented the following: On 4/18/2025, evening shift, Unit 2 and Unit 3 each had only 1 nurse scheduled to work. On 4/19/2025, evening shift, Unit 3 only had 1 nurse scheduled to work, requiring the nurse supervisor to take a cart assignment. On 4/20/2025, evening shift, Unit 3 only had 1 nurse scheduled to work, requiring the nurse supervisor to take a cart assignment. On 4/21/2025, evening shift, Unit 2 had 1 nurse scheduled, and Unit 3 did not have any nurses scheduled to work on the unit. Based on facility census, there were not the required number of Registered Nurses or Licensed Practical Nurses on 4/20/2025, and 4/21/2025. On 4/20/2025, the facility census was 105. There were 14 licensed nurses (Licensed Practical Nurses and Registered Nurses) scheduled to work on that day. The required hours of licensed care for the facility were 115.5 hours based on the census. The licensed staff scheduled accounted for 112 hours of care. On 4/21/2025, the facility census was 108. There were 14 licensed nurses scheduled to work on that day. The required hours of licensed care for the facility were 118.8 hours based on the census. The licensed staff scheduled accounted for 112 hours of care. A review of staffing sheets provided by the facility from 4/14/2025 through 4/21/2025 documented the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on facility census, there were not the required number of Registered Nurses or Licensed Practical Nurses on 4/20/2025 and 4/21/2025. To fulfill the staffing requirement for licensed nursing care (Registered Nurses and Licensed Practical Nurses) per resident per day, a facility with a census of 108 would need to schedule at least 15 staff members with nursing licenses for the entire day. On 4/20/2025, the facility census was 105. The number of scheduled nurses was 14 which equaled 112 hours of nursing care hours. The number of nursing care hours required for a census of 105 residents would be 115.5 hours. On 4/21/2025, the facility census was 108. The number of scheduled nurses was 14 which equaled 112 hours of nursing care hours. The number of nursing care hours required for a census of 108 resident would be 118.8 hours. Based on facility census, there were not the required number of Certified Nurse Aides on any day between 4/14/2025 through 4/21/2025. To fulfill the staffing requirement for Certified Nurse Aide care per resident per day, a facility with a census of 108 would need to schedule at least 33 staff members with Certified Nurse Aides certifications for the entire day. On 4/14/2025, the facility census was 108. The number of scheduled Certified Nurse Aides were 27 which equaled 216 hours of nursing care hours. The number of nursing care hours required for a census of 108 residents was 264.6 hours. On 4/15/2025, the facility census was 108. The number of scheduled Certified Nurse A ides was 30 which equaled 240 hours of nursing care hours. The number of nursing care hours required for a census of 108 residents was 264.6 hours. On 4/16/2025, the facility census was 106. The number of scheduled Certified Nurse Aides were 28 which equaled 224 hours of nursing care hours. The number of nursing care hours required for a census of 106 residents was 259.7 hours. On 4/17/2025, the facility census was 108. The number of scheduled Certified Nurse Aides were 29 which equaled 232 hours of nursing care hours. The number of nursing care hours required for a census of 108 resident was 264.6 hours. On 4/18/2025, the facility census was 108. The number of scheduled Certified Nurse Aides were 30 which equaled 240 hours of nursing care hours. The number of nursing care hours required for a census of 108 resident was 264.6 hours. On 4/19/2025, the facility census was 108. The number of scheduled Certified Nurse A aides were 27 which equaled 216 hours of nursing care hours. The number of nursing care hours required for a census of 108 resident was 264.6 hours. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/20/2025, the facility census was 105. The number of scheduled Certified Nurse Aides were 26 which equaled 208 hours of nursing care hours. The number of nursing care hours required for a census of 105 resident was 257.25 hours. On 4/21/2025, the facility census was 108. The number of scheduled aides were 27 which equaled 216 hours of nursing care hours. The number of nursing care hours required for a census of 108 resident would be 264.6 hours. Interviews: During an interview on 4/14/2025 at 12:25 PM, Certified Nurse Aide #3 stated that the facility had lost a lot of staff and even though there was a sign on bonus offered, staffing was still an issue, especially on the weekend. Certified Nurse Aide #3 stated that resident care was affected by the staffing issues because staff only had enough time to do the bare minimum tasks like feeding and changing residents. To the best of their knowledge, residents were not left sitting in soiled clothing, but the work ethic of some of the staff was lacking. During an interview on 4/18/2025 at 10:53 AM, Licensed Practical Nurse #1 stated there were not enough staff on the unit. They stated Unit 2 was the hardest unit in the building and four (4) staff on the unit was not enough. Multiple residents required two (2)-person assistance and the staff struggled to get to everyone in a timely manner. During an interview on 4/22/2025 at 10:07 AM, Registered Nurse #5 stated that they lacked time to do all the paperwork and take care of the residents on the unit. Registered Nurse #5 stated they did a review of care plans but there was not enough time for them to comb through the care plans and ensure that they were updated as often as they should be. During an interview on 4/22/2025 at 11:12 AM, Director of Nursing #1 stated that they were aware of the staffing regulations and that they believed staffing was both a problem and not a problem. Director of Nursing #1 stated that they believed they staffed the facility as well as they could and even helped out on the units by working a medication cart occasionally, if it was needed. Director of Nursing #1 stated they had a lot of nurses and maybe they needed to be repurposed so that the hours per resident day could be fully met. Some nurses were doing so many jobs that they struggled to keep up. Director of Nursing #1 stated that the facility worked with nursing students from the hospital and colleges. The facility advertised at jobs fairs and offered recruitment bonuses. 10 New York Code Rules and Regulations 415.13(a)(1) (i-iii)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed five (5) percent for two (2) (Resident #s 4 and 78) of four (4) residents observed during a medication pass for a total of 25 observations. This resulted in a medication error rate of eight (8) percent. This is evidenced by: The facility ' s policy and procedure titled, Medication Administration, revised 5/01/2024, documented, medications may be administered by Registered Nurses and Licensed Practical Nurses after satisfactory completion of the medication orientation requirements. Oral Medications: Read Electronic Medical Record, remove medication from drawer and compare label with Electronic Medical Record. Open medication into medicine cup, read label, and leave package. Blister pack must be initialed and dated when blister is opened. Record review of Manufacturer guidelines assessed at https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022516lbl.pdf documented the following: 'Cymbalta (duloxetine extended release) should generally be administered once daily without regard to meals. Cymbalta should be swallowed whole and should not be chewed or crushed, nor should the capsule be opened, and its contents be sprinkled on food or mixed with liquids (2.1).' Resident #4 was admitted to the facility with diagnoses of squamous cell carcinoma scalp and neck (a type of cancer that starts as a growth of cells on the skin), depressive disorder (a common mental disorder that involves a depressed mood or loss of pleasure or interest in activities), and urinary tract infection. The Minimum Data Set (an assessment tool) dated 2/14/2025, documented the resident was cognitively intact, could be understood, and understood others. Resident #78 was admitted to the facility with diagnoses of type two (2) diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), dementia (loss of memory, language, problem-solving and other thinking abilities) and depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities). The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairment, could be understood and usually understood others. During an observation on 4/17/2025 at 9:03 AM, Licensed Practical Nurse #7 reviewed Resident #4 ' s Medication Administration Record. They stated Resident #4 was to receive Duloxetine 60 milligram capsule, delayed release at 9:00 AM, pulled the medication blister pack from medication cart, and then showed the surveyor. Upon observation, it was noted the Medication Administration Record showed order for Duloxetine 60 milligrams to be given at 9:00 AM, but the blister packet given to surveyor was for Doxycycline, 100 milligram capsule. The surveyor pointed out discrepancy to Licensed Practical Nurse #7 at the time of observation. During an interview on 4/17/2025 at 9:03 AM, Licensed Practical Nurse #7 stated they picked up the wrong medication in error and always checked medication again before administering it to residents. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/17/2025 at 9:38 AM, Resident #78 ' s Medication Administration Record documented to give Duloxetine 30 milligrams, delayed release at 9:00 AM. Licensed Practical Nurse #9 removed one (1) Duloxetine, 30 milligrams delayed release capsule, opened the capsule, and poured into a 30-milliliter medication cup. During an interview on 4/17/2025 at 9:38 AM, Licensed Practical Nurse #9 stated they were allowed to crush medications for Resident #78 and that they crushed all medications for this resident. During an interview on 4/17/2025 at 12:04 PM, Director of Nursing #1 stated all nurses had undergone medication administration training upon hire in general orientation, during preceptorship, and with annual competencies. They stated that all nursing staff who administered medication followed the facility policy including the six (6) rights for medication administration: 1. Right Patient, 2. Right Medication, 3. Right Time, 4. Right Dose, 5. Right Route, 6. Right Documentation. Director of Nursing #1 stated instructions for how resident took their medication was located in the information box in electronic medical records They further stated that staff would confirm with the hospital pharmacy that Duloxetine extended-release capsules should not be opened or crushed. Director of Nursing #1 stated Resident #78 took their medication crushed and that the pharmacy and or physician should had been notified so that an alternative drug could had been prescribed. 10 New York Codes, Rules, and Regulations 415.12 (m)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for two (2) (Unit 100 and Unit 300) of two (2) Medication Rooms; and three (3) (Unit 100, 200 and 300) of three (3) Medication Carts reviewed. Specifically, (a.) two medications had expired; (b.) one open bottle of tuberculin Purified Protein Derivative (PPD) solution had expired; (c.) one Humalog Kwik pen had an illegible open date; (d.) four open inhalers had no open or expiration date; one unopened inhaler had an open date; (e.) one bottle of eye drops had no open and or expiration date (f.) two bottles of eye drops had open and or expiration date discrepancies; (g.) an unopened Solostar Kwik insulin pen was in medication cart unrefrigerated. This is evidenced by: Regulation 483.45(g) Labeling of Drugs and Biologicals, documents Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. During an observation on [DATE] at 11:35 AM, Unit 300, Medication Room contained 1 bottle of sleep aid stock medication with an expiration date of ,d+[DATE]; and 1 bottle of melatonin stock medication with an expiration date of ,d+[DATE]. Unit 300 medication cart #6 contained 1 Humalog Insulin Kwik pen with an illegible date; 1 unopened bottle of carboxymethylcellulose sodium 0.5% eye drops dated ,d+[DATE]. 1 opened bottle of carboxymethylcellulose sodium 0.5% eye drops with date discrepancy. The box had date of [DATE] the bottle was dated [DATE]. Unit 300 mediation cart #6 also contained an open albuterol inhaler dated [DATE] and no expiration date, and an unopened albuterol inhaler with date of [DATE]. During an interview on [DATE] at 11:35 AM, Licensed Practical Nurse #2 was unable to verbalize open and or expiration dates for insulin, eye drops or inhalers. They were not aware of any resources from pharmacy of medications with shortened expiration dates after opening. During an observation on [DATE] at 12:34 PM, Unit 100 Cart #1 was observed with laptop open revealing medication administration record for Resident #99. Unit 100 medication room contained 1 open bottle of tuberculin Purified Protein Derivative (PPD) that had expired as of [DATE]. Unit 100 cart #1 contained 1 open bottle of Systane eye drops; 2 Breo Ellipta inhalers; 1 Anoro Ellipta inhaler with no open and or expiration dates. During an observation on [DATE] at 1:20 PM, Unit 200 cart #3 contained 1 Breo Inhaler with no open and or expiration dates; 2 Admelog Solostar insulin kwik pens; 1 pen was dated [DATE] with no expiration date; the other pen was unopened and stored in mediation cart. During an interview on [DATE] at 01:20 PM, Licensed Practical Nurse #3 stated unopened insulin should be kept in refrigerator until ready for use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 12:04 PM, Director of Nursing #1 stated all nursing staff were responsible for ensuring the medication cart and room they had been assigned to were clean and orderly. All medications should be labeled with an open and expiration date. Medications with shortened expiration dates after opening were covered during initial and annual nurse competencies. In-house pharmacy was available as a resource. 10 New York Codes, Rules, and Regulations 415.18(e)(,d+[DATE])

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36922 Based on observations, record reviews, and interviews during the recertification survey, the facility did not ensure that food was prepared by methods that conserved the food ' s nutritive value, flavor and appearance and were palatable for 18 (Resident #s 1, 2, 4, 9, 21, 23, 31, 32, 39, 48, 59, 63, 64, 68, 90, 91, 92, and 94) of 22 residents who were reviewed for palatable and attractive food and drink. Specifically, (a.) During an interview during Resident Council held on [DATE], six (6) residents complained that the food was inedible and cold, that drinks were warm, vegetables were hard and under cooked, and that the meat was tough. (b.) Resident # ' s 1, 9, 21, 23, 31, 32, 63, 64, 68, 90, 91, 92, and 94 complained of food being of not palatable with meat being overcooked and vegetables undercooked, tasteless and without variety. (c.) Residents on one (1) of three (3) units received expired milk. This is evidenced by: The facility policy titled, Resident Rights and Dignity, dated ,d+[DATE], documented that the facility was responsible to offer food substitutes of similar nutritive value if the food offered was refused. Additionally documented was that the facility would provide assistance with eating and special eating equipment or assistive devices and utensils if needed. The facility policy titled, Use and Storage of Food Brought to Resident from Outside the Facility, dated , d+[DATE], documented that nursing was responsible for keeping the personal refrigerator in the resident ' s room in compliance with food safety by verifying and documenting refrigerator temperatures as well as checking content dates/condition once daily. Maintenance Department would be notified for corrective action if a temperature was found to be non-compliant (above 41 degrees). Dining Service would provide the appropriate training to nursing. During an interview during Resident Council held on [DATE], 6 residents complained that the food was inedible and cold, that drinks were warm, vegetables were hard and under cooked, and that the meat was tough. During an interview conducted during resident lunch service on [DATE] at 1:09 PM, Resident #94 statedthey had complaints about the chicken they received. They stated it was not what they ordered, and it was dry. Resident #94 stated that they had ordered a hamburger, but they were hungry, so they would eat what they were given. During an observation of resident lunch service on [DATE], several residents complained that the chicken was dry and that the rice was not good. During an interview on [DATE] at 10:41 AM, Resident #31 stated the food was not good. During an interview on [DATE] at 11:13 AM, Resident #9 stated the food was not great, and that they did not get what they asked for frequently. During an interview on [DATE] at 11:21 AM, Resident #21 stated that the food was awful, the residents were given bad cuts of meat, and the food was not prepared properly. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 2:32 PM, Resident #94 stated that food was never what they ordered, did not have any taste and was dry. During a test of lunch trays on [DATE] at 12:30 PM, Resident #92 ' s tray was noted to have the following items (and observed conditions of them in parentheses): Ensure (a liquid nutritional supplemental drink), cooked carrots (which were noted to be hard to bite), potatoes, beef (noted not to have much flavor), juice (which was noted to be warm at 60 degrees), and hot coffee. 48615 During a test of lunch trays on [DATE] at 12:53 PM, Resident #21 ' s tray was noted to have the following items (and observed conditions of them in parentheses): pot roast (noted to be difficult to cut with a knife), roasted potatoes, and cooked carrots and celery (noted to be too hard to be cut with a fork). During a test of lunch trays on [DATE] at 1:04 PM, Resident #31 ' s tray was noted to have the following items (and observed conditions of them in parentheses): whole milk (that expired on [DATE] and warm at 56. 1 degrees), orange juice (noted to be warm at 50 degrees), factory packaged diced pears, Ensure (noted to be warm at 68.8 degrees), grilled cheese (noted to be crispy on the bottom and soggy on the top), mixed vegetables (noted to be hard and crunchy), beef with gravy (noted to have some chewy pieces), and mashed potatoes (noted to be watery looking and without taste). Upon discovery of the expired milk on Resident #31 ' s tray (which was one of the last trays to be passed on the unit), Licensed Practical Nurse #7, called down to the kitchen and stated that they needed to check the milk, that expired milk had been sent to the floor and ' you know who found it. ' 48744 During an interview on [DATE] at 12:00 PM, Activities Aide #1 stated residents had been complaining since the food service changes occurred a month ago. They stated residents complainted vegetables and meats were cooked in such a fashion that they were unable to chew, cut, and struggled to chew food served to them. During an interview on [DATE] at 11:33 AM, Food Service Director #1 stated there were some concerns voiced at the food council meeting held on [DATE]. They had been addressing what they believed was the most pressing issue, that food trays were not being delivered in a timely fashion. There were separate food meetings from resident council and that there were concerns and the concerns were being worked on and addressed. They stated the warm temperature juice and milk were most likely because they were in the tray carts with the warm food. They hadn ' t met with any residents individually, just during resident council meetings and food meetings. After they were made aware that expired milk was found on the unit, they were called by the staff and had the kitchen staff go through all of the drinks stored in the kitchen and pull anything outdated. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on [DATE] at 11:40 AM, Clinical Nutrition Manager #1 stated there had been a change in food service, they had some complaints of food being under or over cooked. Clinical Nutrition Manager #1 stated that the residents could have their diets changed to ground meat and pureed vegetables if they were unable to chew the food that was served. Clinical Nutrition Manager #1 stated that they had not met individually with any residents and that they were all still getting used to the new system being used at the facility. The Clinical Nutrition Manager stated that during the menu planning and food service committee meeting, residents complained about a fish dinner that was so inedible that the dish was removed from options for a meal. They stated there were no complaints made regarding food temperatures from residents to the best of their knowledge. 10 New York Code of Rules and Regulations 415.14(d)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21414 Based on observations and interviews conducted during the recertification survey, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety in the main kitchen. Specifically, the automatic dishwashing machine was not sanitizing, floors were not clean, and concentration of the chemical sanitizing rinse in the 3-compartment sink was low. This is evidenced by: During observations on 4/14/2025 at 10:32 AM through 11:08 AM: The automatic dishwashing machine thermometer read 140 degrees Fahrenheit during the final rinse cycle. The walk-in freezer floor and floor under cooking equipment was soiled with food particles and/or a black build-up. The concentration of quaternary ammonium compound that was used to sanitize food contacted equipment in the 3-compartment sink was zero parts per million of quaternary ammonium compound measured at 74 degrees Fahrenheit. During an interview on 4/14/2025 at 10:52 AM, Food Service Worker #1 stated that the automatic dishwashing machine drain lever may have been dislodged from the closed position by a bus cart; this would cause the dishwashing machine to keep cycling new and lower temperature water into the sanitizing final rinse, would not achieve 180 degrees Fahrenheit, and would cause a low thermometer temperature. During an interview on 4/14/2025 at 11:09 AM, Culinary Director #1 stated that they would contact the vendor to have the concentration of chemical sanitizer adjusted and would have the floors cleaned. 10 New York Codes, Rules, and Regulations 415.14(h) Chapter 1 State Sanitary Code Subpart 14-1

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36922 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure they established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for five (5) (Resident # ' s 21,35,92, 95, and 99) of 15 residents reviewed for infection control. Specifically, (a.) Resident #s 21, 35, 92, and 95 had wounds that required dressing changes and were not placed on Enhanced Barrier Precautions; and (b.) for Resident #99, infection control practice was not maintained during a dressing change and skin treatment. This is evidenced by: The facility policy, Nursing Home Infection Prevention and Control Program, revised 1/2023, documented the following: Under Policy: There is an active, effective, facility wide infection control program for the surveillance, prevention and control of infections as well as reporting of communicable diseases and increased incidence of infections. Under Responsibility: To maintain a record of incidents and corrective actions related to infections and report them to the Infection Control Committee. The Infection Preventionist will: (a) perform surveillance and investigation to prevent, to the extent possible, the onset and spread of infection; (b) prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions; (c) use records of infection incidents to improve its infection control processes and outcomes by taking corrective actions, as indicated; (d) implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination; and (e) properly store, handle, process, and transport linens to minimize contamination. Resident #21 Resident #21 was admitted to the facility with diagnoses of squamous cell carcinoma of skin of scalp and neck (cancer cells that form on the surface of the skin), type 2 diabetes mellitus with diabetic neuropathy (endocrine dysfunction that causes issues regulating blood sugar that causes damage to nerves in the legs, feet and hands), and morbid obesity (excessive body fat that causes a body mass index of 40 or higher). The Minimum Data Set (an assessment tool) dated 3/07/2025, documented that the resident was able to be understood and understand others, with minimal cognitive impairment. A review of Resident #21 ' s physician orders on 4/21/2025 showed evidence that Resident #21 required a dressing change to their heel every three days, and as needed, and to check the dressing condition every shift, daily. There was no documented evidence that Resident #21 had an order for Enhanced Barrier Precautions. 48615 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #35 Resident #35 was admitted to the facility with diagnoses of unspecified benign neoplasm of penis (non-cancerous growth or tumor that arises on the penis), severe protein-calorie malnutrition (a condition characterized by a combination of severe protein deficiency and calorie deficiency, leading to significant physical consequences), and intellectual disabilities (condition characterized by limitations in cognitive functioning and skills). The Minimum Data Set, dated dated dated [DATE], documented the resident to be had minimal cognitive impairment, could be understood, and understand others. A review of Resident #35 ' s physician orders on 4/21/2025 documented Resident #35 required a dressing change to their bilateral heels every 3 days, and as needed. There was no documented evidence that Resident #35 had an order for Enhanced Barrier Precautions. 48744 Resident #99 Resident #99 was admitted to the facility with diagnoses of unspecified severe dementia with agitation (a progressive degenerative memory disease that can cause severe physical or verbal aggression), type 2 diabetes mellitus without complications (an endocrine dysfunction that causes irregular blood sugar levels), and obstructive sleep apnea (a sleep disorder that causes episodes of complete airway collapse or partial collapse with decrease in oxygen saturation). The Minimum Data Set, dated dated dated [DATE], documented that the resident was sometimes understood and sometimes understand others, and had severe cognitive impairment. Resident #99 ' s Comprehensive Care Plan for Skin Integrity, effective 8/22/24 and revised 9/18/2024, documented Resident #99 had bilateral unstageable heel wounds that required care. The note update by Registered Nurse #7 on 11/15/2024 documented Resident #99 ' s treatment; cleanse the right heel, allow to dry, and cover with Mepilex dressing every 3 days and as needed. The left heel was noted to be closed but received the same treatment. The care plan was again updated on 2/14/2025 with Registered Nurse #7 ' s note indicating that the wound care team was following wound progress and interventions were to continue. The Physician order dated 3/21/2025 at 3:44 PM documented Resident #99 was to have the right heel cleansed with Vashe skin cleanser, allow to dry and cover with heel Mepilex dressing every 3 days and as needed. Document/report any signs or symptoms of infection or change. During an observation on 4/21/2025 at 3:20 PM, Licensed Practical Nurse #7 was observed changing the dressing to Resident #99 ' s heel. They applied a gown and gloves and removed the old dressing. Licensed Practical Nurse #7 did not change the gloves they were wearing after removing the soiled dressing. Licensed Practical Nurse #7 washed Resident #99 ' s wound area from the outside in, instead of inside to out with Vashe wound cleanser and when they pulled the clean dressing from its wrapper, Licensed Practical Nurse #7 fanned the open wound with the dressing to help increase drying time. The dry dressing was applied and covered with a heel Mepilex. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/21/2025 at 3:30PM, Licensed Practical Nurse #7 was asked when they were last trained on infection control and dressing changes. Licensed Practical Nurse #7 stated that they had been out for two (2) months and were catching up on their competencies. They stated that they did not know when they had their last training. During an interview on 4/22/2025 at 10:37 AM, Infection Preventionist Supervisor #1 (supervisor of the facility ' s Infection Preventionist) stated they were able to speak to general policies but not specific facility practices. Infection Preventionist Supervisor #1 stated that Enhanced Barrier Precautions were ordered for residents with foley catheters or wounds. Contact Precautions were used for residents with active infections, not residents colonized with multiple drug resistant organisms, like Methicillin-resistant Staphylococcus aureus (a group of gram-positive bacteria that are genetically distinct from other strains of Staphylococcus aureus and is responsible for several difficult-to-treat infections in humans) or Escherichia coli (E coli, a gram-negative coliform bacterium that is commonly found in the lower intestine of warm-blooded organisms). Infection Preventionist Supervisor #1 stated that the facility aimed for the least restrictive barrier precaution and that there were studies that showed that residents with contact precautions received fewer social interactions, and it increased the likelihood of staff avoiding residents with contact precautions. Infection Preventionist Supervisor #1 stated that Infection Preventionist #1 had done audits and observed staff compliance with donning and doffing personal protective equipment, and that the facility strived to have good infection control policies and procedures. During an interview on 4/22/2025 at 11:12 AM, Director of Nursing #1 stated that precautions used were based on devices used by residents, such as foley catheters or central lines, and resident conditions, such as open wounds, and infections. The type of precautions used were based on if infections were active versus chronic. The examples given included a resident with an infected open wound would require Contact Precautions, but a resident with a wound infection that had been treated, and did not require antibiotics, would only need Enhanced Barrier Precautions. When asked if a resident with a multiple drug-resistant organism in their urine, and with a foley catheter, would require Contact or Enhanced Barrier Precautions, Director of Nursing stated that only active infections required Contact Precautions and colonized, but not active organisms, required Enhanced Barrier Precautions. Director of Nursing #1 stated that when Infection Preventionist #1 returned, they would have an in-depth discussion on the difference in precautions and what they should be for residents colonized with multiple drug-resistant organisms, wounds, and foley catheters. Director of Nursing #1 stated that any order for precautions of any kind required a physician ' s order. 10 New York Codes, Rules and Regulations 415.19(a)(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observations and interviews conducted during a recertification survey from 4/14/2025 - 4/22/2025, the facility did not ensure the environment was functional, sanitary, and comfortable for residents, staff, and the public. Specifically, all three units (100, 200 and 300) had foul smelling odors of urine and feces. Unit 100 carpet was soiled with multiple stains throughout; Unit 200 had dirty linens under sink and Unit 300 had smelled consistent with cannabis. This is evidenced by: The Facility ' s Policy and Procedure titled, Personal Appearance, revised 3/17/2025, documented the policy intends to provide a general expectation for personal appearance for facility ' s employees and is not meant to capture all necessary dress and appearance requirements nor represent a complete listing of clothing or items of apparel acceptable throughout the facility. All employees are to take positive steps toward ensuring that they present an overall professional image. Employees with offensive odor upon their person or clothing, including but not limited to tobacco or marijuana, will be sent home to change clothes or eliminate the smell (e.g. brushing teeth, bathing, etc.). During an observation on 4/14/2025 at 11:00 AM, noted strong odor of feces in hallway that included room [ROOM NUMBER]. The carpeted floor had multiple stains. During an observation on 4/15/2025 at 9:30 AM, a strong odor of feces on unit 100 common area was noted. Licensed Practical Nurse #6 was made aware at the time of the observation. They stated they would tell the aide. There was no care provided to any resident sitting in the common area for 20 minutes. During an observation on 4/17/2025 at 10:45 AM, there was a heavy urine and feces smell on 200-unit, outside of room [ROOM NUMBER]. Dirty linen was observed on the floor under the sink. During an observation on 4/17/2025 at 10:53 AM, there was a smell of urine in the hallway outside of room [ROOM NUMBER]. During an observation on 4/17/2025 at 11:40 AM on the 300-unit, a strong odor of smoke consistent with cannabis was noted near Medication Cart #6. During an interview on 04/17/2025 at 11:00 AM, Director of Nursing #1 stated staff identified one (1) resident on unit 100 sitting in common area that required care. They further stated that housekeeping cleaned units throughout the day. Units 200 and 300 carpets were replaced with laminate flooring, but that at this time, the carpet on unit 100 was not budgeted for replacement. During an interview on 04/17/2025 at 11:40 AM, Licensed Practical Nurse #6 stated they recently came in and had smoked prior to coming into the building. Upon this interview, surveyor relayed this interview to Administrator #1, and Licensed Practical Nurse #6 was immediately sent home. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/17/2025 at 12:04 PM, Director of Nursing #1 stated staff were only to smoke in designated smoking areas. They stated staff who enter the building with the smell of smoke were in violation of the facility ' s Personal Appearance Policy, and if identified would be sent home to change into appropriate clothing. During an interview on 04/21/2025 at 12:01 PM, Administrator #1 stated they did not recall the smell of cannabis in the past. They stated they had reports from residents complaining of staff smelling of cigarette smoke. They stated one example was a Certified Nurse Aide who smoked in their car and then came back into building smelling of smoke; the staffer was educated on the facility ' s personal appearance policy. 10 New York Codes, Rules, and Regulations 415.29