STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335098	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Finger Lakes Health	75 Mason Street Geneva, NY 14456

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observations, interviews, and record review, the facility failed to ensure an allegation of neglect and an incident involving an injury of unknown source was reported to the State Survey Agency for one (1) of eight (8) residents reviewed (Resident #98). Specifically, Resident #98 experienced a fall from a full body lift resulting in a head injury requiring staples, and the facility did not report the incident to the State Survey Agency as required.The findings include:The facility policy Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property last reviewed 06/27/2024 included alleged violations involving abuse, neglect, or mistreatment, including injuries of unknown source, will be reported to the State Survey Agency within required timeframes, including within two (2) hours if the events involve serious bodily injury.Resident #98 had diagnoses including stroke (a condition where blood flow to the brain is interrupted), neuropathy (peripheral nerve damage), and hemiplegia (weakness or paralysis affecting one side of the body). The Minimum Data Set (a resident assessment tool) dated 03/02/2026 documented the resident had moderately impaired cognition and was dependent for transfers.Review of Resident #98's comprehensive care plan and Kardex (care plan used by certified nursing assistants to direct care) last revised 11/11/2025 documented the resident required a full body lift with assistance of two (2) staff for transfers.Review of the facility incident and accident report dated 11/11/2025 documented Resident #98 fell from a full body lift during a transfer and sustained a head laceration with bleeding.Review of emergency department documentation dated 11/11/2025 revealed Resident #98 sustained a head laceration requiring staples following the fall.During an interview on 04/01/2026 at 3:12 PM, the Director of Nursing stated the incident was not reported to the State Survey Agency because they did not consider it reportable.During an interview on 04/07/2026 at 3:46 PM, Nurse Practitioner #1 stated no one could determine what caused the fall.During an interview on 04/07/2026 at 5:40 PM, the Director of Nursing stated the facility could not determine the cause of the incident.Title 10 New York Codes, Rules and Regulations, Section 415.3(h)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335098	A. Building B. Wing	04/08/2026

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure allegations and incidents were thoroughly investigated and documented, including identification of root cause and implementation of corrective actions, for two (2) of eight (8) residents reviewed (Residents #98 and #131). Specifically, the facility failed to conduct a thorough and complete investigation for Resident #98 following a fall from a full body lift resulting in a head injury, and for Resident #131 following a thermal burn (a skin injury caused by contact with heat sources like hot liquids, causing tissue damage) incident related to reheated food. The findings include:The facility policy Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property last reviewed 06/27/2024 included alleged violations will be thoroughly investigated, including collection of statements, review of relevant documentation, and identification of contributing factors, and appropriate corrective actions will be implemented to prevent recurrence.1. Resident #98 had diagnoses including stroke, neuropathy (peripheral nerve damage), and hemiplegia (weakness or paralysis affecting one side of the body). The Minimum Data Set, dated [DATE] documented the resident had moderately impaired cognition and was dependent for transfers.Review of the facility incident and accident report dated 11/11/2025 revealed Resident #98 fell from a full body lift during a transfer and sustained a head laceration requiring transfer to the emergency room.Review of emergency department documentation dated 11/11/2025 revealed Resident #98 required staples for a head laceration following the fall.Review of the facility Incident and Accident report dated 11/11/2025 revealed no documented evidence of a completed investigation, including no documented root cause analysis, no determination of contributing factors, and no documented corrective actions.During an interview on 04/01/2026 at 3:38 PM, Registered Nurse Supervisor #2 stated they completed the initial report and collected statements, and the Nurse Manager and Director of Nursing were responsible to continue the investigation.During an interview on 04/07/2026 at 4:03 PM, Registered Nurse Manager #1 stated they were not aware if an investigation had been completed.During an interview on 04/07/2026 at 3:46 PM, Nurse Practitioner #1 stated no one requested a statement them and no one could determine what caused the fall.During an interview on 04/07/2026 at 5:40 PM, the Director of Nursing stated the facility could not locate documentation of an investigation and could not determine the cause of the incident.2. Resident #131 had diagnoses including a left tibia fracture (broken shinbone), anxiety, and bipolar disorder (a mental health condition characterized by emotional highs and lows). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and required set-up assistance with eating.Review of the facility Incident and Accident report dated 01/20/2026 revealed Resident #131 sustained thermal burns to the face and chest after spilling reheated soup.Review of the New York State Department of Health incident intake dated 01/21/2026 revealed Resident #131 sustained redness and blistering following the incident.Review of the facility investigation did not include documented evidence if reheating temperatures were obtained, did not include review of the Cooking and Reheating Temperature Log, and did not include whether staff followed the reheating policy.During an interview on 04/01/2026 at 4:14 PM, Certified Nursing Assistant #13 stated they reheated the soup and obtained a temperature reading but did not document it.During an interview on 04/08/2026 at 8:43 AM, the Director of Nursing stated the investigation should have included review of temperature logs and staff compliance with reheating procedures, and absence of this information resulted in an incomplete investigation.Title 10 New York Code of Rules and Regulations, Section 415.4 (b)(3-4)

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NAME OF PROVIDER OR SUPPLIER: Finger Lakes Health		STREET ADDRESS, CITY, STATE, ZIP CODE: 75 Mason Street Geneva, NY 14456	

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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure care and services were provided in accordance with the resident's needs and professional standards for two (2) of eight (8) residents reviewed (Residents #96 and #131). Specifically, Resident #96 who had a diagnosis of dysphagia (difficulty swallowing that can lead to choking, coughing, or food feeling stuck in the throat), received a diet inconsistent with their swallowing needs due to failure to implement and communicate a diet recommendation and supervision needs, and experienced a choking episode requiring abdominal thrusts. Additionally, Resident #131 sustained thermal burns (a skin injury caused by contact with heat sources like hot liquids, causing tissue damage) after staff failed to follow safe food reheating practices. This resulted in actual harm for Residents #96 and #131 that was not Immediate Jeopardy.The findings include: The facility policy Change in Condition, Management and Notification last revised 04/05/2023, included all changes in a resident's physical, social, or mental condition will be reported to the charge nurse or registered nurse immediately. Conditions to be reported to the nurse include, but are not limited to, physical illness, complaints or indicators of pain, and deterioration of functional ability including eating. The medical provider, and the resident and/or resident representative will be notified when there is an accident involving the resident which results in injury and has the potential for requiring medical intervention or a need to alter treatment significantly. The medical provider will be notified when a recommendation is made by other disciplines or consultants, which may affect the resident's plan of care and all disciplines will update the plan of care accordingly.The facility policy Reheating Resident Food and Microwave Use dated 11/21/2025 included only facility staff may use microwave ovens, staff must be present during reheating, reheated foods must reach a minimum internal temperature of 135 degrees Fahrenheit for hot holding, and soups or leftovers must be reheated to 165 degrees Fahrenheit. Staff are required to obtain two (2) internal temperature readings and document the product name, time, and temperature readings on the Cooking and Reheating Temperature Log.1. Resident #96 had diagnoses including dysphagia, dementia, and stroke. The Minimum Data Set (a resident assessment tool) dated 10/27/2025 documented the resident was cognitively intact and required set-up assistance with eating.Review of Resident #96's Comprehensive Care Plan dated 03/14/2025 revealed the resident had nutritional problems related to diet restrictions and dementia. Interventions included: staff were to monitor, document, and report signs of dysphagia including pocketing food, choking, coughing, drooling, holding food in mouth, and several attempts at swallowing, and the Registered Dietician to evaluate and make diet change recommendations as needed.Review of Resident #96's medical orders revealed a swallow evaluation due to dysphagia dated 10/03/2025, a swallow evaluation due to a choking episode dated 11/02/2025, a carbohydrate consistent diet, minced and moist level five (5) texture (soft, moist, and easily formed into a mass of food requiring minimal chewing) with honey thick fluids dated 11/02/2025, and a carbohydrate consistent diet soft, bite sized level six (6) texture (tender, moist, bite-sized pieces requiring some chewing) with regular fluids dated 11/03/2025.A facility investigation dated 11/03/2025 documented during a care plan meeting on 10/02/2025, Resident #96's family reported difficulty swallowing and need for reminders to slow down while eating. A recommendation was made for a speech evaluation and diet downgrade. An order was entered into the electronic health record; however, it was not transferred to the dietary system. On 11/02/2025, the resident choked on a ground meatball and required six (6) to seven (7) abdominal thrusts.During an interview on 04/01/2026 at 1:21 PM, Registered Nurse Manager #1 stated after a medical order is entered into the electronic health record, nursing is responsible to confirm the order, document it, and enter it into a separate system used to communicate with other departments, including dietary. Registered Nurse Manager #1 stated it was likely the order was confirmed in the electronic health record but not entered into the second system and they had observed orders being (continued on next page)

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Finger Lakes Health	75 Mason Street Geneva, NY 14456

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	partially entered before.During an interview on 04/06/2026 at 10:03 AM, Registered Nurse Manager #1 stated Resident #96 required set-up assistance and supervision with meals and both should be documented so staff would not leave the resident alone while eating. Registered Nurse Manager #1 stated the supervision requirement may have been accidentally deleted. The Kardex was last updated on 11/03/2025.During an interview and observation on 04/06/2026 at 10:18 AM with the Clinical Informatics Registered Nurse and Registered Nurse Manager #1, the Clinical Informatics Registered Nurse stated they could not produce documentation reflecting what the Kardex indicated at the time of the choking event. Review of historical documentation revealed the resident was listed as requiring set-up assistance. Registered Nurse Manager #1 confirmed the resident should have required supervision.During an interview on 04/06/2026 at 10:35 AM with Certified Nursing Assistant #4 and Certified Nursing Assistant #12, Certified Nursing Assistant #4 stated if a resident required supervision, staff must remain with the resident during meals, and if a resident required set-up assistance, staff would assist with meal preparation and were not required to stay. Certified Nursing Assistant #12 reviewed the assignment sheet dated 04/06/2026, which documented Resident #96 required set-up assistance and did not include supervision.During an interview on 04/07/2026 at 10:30 AM, the Rehabilitation Manager/Physical Therapist stated a speech evaluation order was entered on 10/03/2025 but was not received by therapy because it was not entered into the second system used to communicate orders, and the evaluation did not occur.During an interview on 04/07/2026 at 3:14 PM, the Medical Director stated if a recommended diet change was not implemented and the resident continued to receive a regular diet, it would subject the resident to a swallowing hazard.During an interview on 04/07/2026 at 3:34 PM, the Director of Nursing stated the diet should have been downgraded following the care plan meeting on 10/02/2025 and staff should have had documentation in place to prompt supervision and reminders to slow down while eating.2. Resident #131 had diagnoses including a left tibia fracture (broken shinbone), anxiety, and bipolar disorder (a mental health condition characterized by emotional highs and lows). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and required set-up assistance with eating.Review of Resident #131's comprehensive care plan, last revised 02/17/2026, revealed the resident required set-up assistance with eating and received a regular diet with thin liquids.A facility Incident and Accident report dated 01/20/2026 documented Resident #131 spilled hot soup onto their face, chin, and chest after reheating by staff.Review of the New York State Department of Health Incident intake dated 01/21/2026 revealed Resident #131 sustained redness and blistering to the chin and chest following the incident.Review of the medical provider progress note dated 01/21/2026 revealed Nurse Practitioner #2 documented Resident #31 was assessed for second degree burns and was found to have small intact blisters to the chin and upper chest with surrounding redness.Review of the Cooking and Reheating Temperature Log dated 01/20/2026 revealed no documentation was available for the reheated soup.During an interview on 04/01/2026 at 4:14 PM, Certified Nursing Assistant #13 stated they reheated the soup in the microwave for multiple intervals and obtained a temperature of 130 degrees Fahrenheit and did not document the temperature because a log was not available.During an interview on 04/02/2026 at 9:07 AM, the Director of Nursing stated Certified Nursing Assistant #13 did not follow the reheating policy, did not obtain required temperature readings, and this information was not included in the facility investigation.Title 10 New York Code of Rules and Regulations, Section 415.12

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NAME OF PROVIDER OR SUPPLIER Finger Lakes Health		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Mason Street Geneva, NY 14456	

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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 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and did not ensure adequate supervision and assistive devices were provided to prevent accidents for four (4) of eight (8) residents reviewed (Residents #65, #75, #98, and #101). Specifically, Residents #65, #75, and #101 were at risk for accidents related to inconsistent and unsafe use of full body lift slings (a fabric device used with a mechanical lift to support and transfer a resident) including use of incorrect sling sizes and reuse of disposable slings. Resident #98 experienced a fall on 11/11/2025 from a full body lift, resulting in a head injury that required staples. This resulted in actual harm for Resident #98 that was not Immediate Jeopardy.The findings include: The facility policy Lift and Transfer last reviewed 05/05/2024 included all direct care employees will receive training on mechanical lift use and transfer techniques including use of slings, and the Nurse Manager or designee is responsible for ensuring employee training is complete and ensuring transfer information is updated.1. Resident #98 had diagnoses including stroke, neuropathy (peripheral nerve damage), and hemiplegia (weakness or paralysis affecting one side of the body). The Minimum Data Set (a resident assessment tool) dated 03/02/2026 documented the resident had moderately impaired cognition and was dependent for transfers. Record review on 04/01/2026 of Resident #98's Comprehensive Care Plan did not include the use of a mechanical lift for transfers.Record review of Resident #98's Kardex (used by certified nursing assistants to guide resident care), last revised 11/11/2025, documented the resident required a full body lift with assistance of two (2) staff for transfers. The size of the sling was not documented.Record review of manufacturer guidelines and Resident #98's weight of 179.9 pounds (as of 11/10/2025) revealed the resident required a large sling.Record review of the facility Incident and Accident report dated 11/11/2025 documented Resident #98 fell from a full body lift during a transfer, sustained a head laceration with bleeding, and was transferred to the emergency room for evaluation.Record review of Emergency Department documentation dated 11/11/2025 revealed Resident #98 sustained a head laceration requiring staples following a fall from a lift.During an interview on 04/01/2026 at 4:01 PM, Certified Nursing Assistant #2 stated during the transfer, Resident #98 tipped backward and fell from the sling, and they did not think the sling was properly positioned before the lift was moved.During an interview on 04/07/2026 at 3:46 PM, Nurse Practitioner #1 stated no one could determine exactly what caused the fall and no statements were requested from them.During a telephone interview on 04/07/2026 at 4:55 PM, the Medical Director stated they would have expected the facility to have performed an investigation into the event involving Resident #98 on 11/11/2025 so an event like that did not happen again.During an interview on 04/07/2026 at 5:40 PM, the Director of Nursing stated the facility could not locate documentation of a completed investigation and could not determine what caused the fall.2. Resident #101 had diagnoses including hemiparesis (weakness or partial paralysis affecting one side of the body), osteoarthritis (joint disease that causes pain, stiffness, and reduced mobility), and hypertension (high blood pressure). The Minimum Data Set, dated [DATE] documented the resident had severely impaired cognition and was dependent for transfers.Record review of Resident #101's Comprehensive Care Plan, last revised 01/14/2026, current Kardex reviewed on 04/02/2026, and assignment sheet dated 04/06/2026, revealed the resident required a full body lift with assistance of two (2) staff for transfers. The size of sling was not documented.Record review of manufacturer guidelines and the resident's most recent weight of 146.4 pounds revealed the resident required a size medium sling.During an observation on 04/02/2026 at 1:47 PM, Certified Nursing Assistant #9 and Certified Nursing Assistant #10 were preparing to transfer Resident #101 using an extra-large sling. The surveyor intervened and stopped the transfer. During an interview on 04/02/2026 at 1:56 PM, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Registered Nurse Manager #2 stated Resident #101 required a medium sling, but the staff used an extra-large sling to transfer Resident #101 because it was the only sling available at that time. 3. Resident #75 had diagnoses including hemiplegia, convulsions, and muscle spasm. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and dependent for transfers.When reviewed on 04/02/2026, Resident #75's current Kardex documented the resident required a full body lift with an extra-large sling.Review of Resident #75's most recent weight on 04/02/2026 revealed the resident weighed 275 pounds.During an observation on 04/02/2026 at 12:06 PM, Resident #75 was seated in a recliner with a large sling in place.During an interview on 04/02/2026 at 12:06 PM, Registered Nurse Manager #3 stated that based on weight, the resident should have been in an extra-large sling, and the incorrect sling size was used.During an interview on 04/03/2026 at 10:10 AM, Certified Nursing Assistant #5 stated on 04/02/2026 they transferred Resident #75 using a large size sling and acknowledged it should have been an extra-large sling.4. Resident #65 had diagnoses including chronic pain (persistent pain lasting longer than three (3) to six (6) months), peripheral vascular disease (a blood circulation disorder that affects the arteries in the legs), and heart failure (a condition where heart cannot pump enough blood to meet the body's needs. The Minimum Data Set, dated [DATE] documented the resident had moderately impaired cognition and required maximum assistance for transfers.Review of Resident #65's Kardex reviewed on 04/02/2026 documented the resident required a full body lift with assistance of two (2) staff for transfers. The sling size was not documented.During an observation on 04/02/2026 at 2:34 PM, a disposable sling with a visible wash indicator marking it as unsafe for use was observed on the resident's wheelchair. When interviewed at 2:39 PM, Certified Nursing Assistant #1 stated the sling was intended to be reused.During an interview on 04/02/2026 at 8:44 AM, Certified Nursing Assistant #6 stated sling size selection was based on a visual inspection of the resident.During an interview on 04/02/2026 at 8:50 AM, Licensed Practical Nurse #1 stated they would ask a certified nursing assistant or refer to the care plan to determine sling size and were not trained on lift use.During an interview on 04/02/2026 at 8:54 AM, Certified Nursing Assistant #9 stated sling size was determined by experience and familiarity with the resident's body size.During an interview on 04/02/2026 at 9:03 AM, Certified Nursing Assistant #7 stated they would use the sling available in the room or ask a nurse.During an interview on 04/02/2026 at 9:10 AM, Licensed Practical Nurse #2 stated sling size was not documented in the care plan or Kardex.During an interview on 04/02/2026 at 9:25 AM, Certified Nursing Assistant #5 stated they did not know where sling size was documented.During an interview on 04/02/2026 at 9:50 AM, Registered Nurse Manager #2 stated sling size should be determined based on weight and manufacturer guidelines, but staff often relied on a visual inspection of a resident's physical appearance and body size.During an interview on 04/02/2026 at 9:07 AM, the Director of Nursing stated the facility had experienced issues with sling availability and compatibility and disposable slings were being used in place of reusable slings.During an interview on 04/02/2026 at 2:05 PM, the Director of Nursing stated if the correct sling size was not available, staff should obtain the correct size from another unit and should not proceed with the transfer using an incorrect sling.Title 10 New York Code of Rules and Regulations, Section 415.12 (h)(1)