STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335457	A. Building B. Wing	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fiddlers Green Manor Rehab and Nursing Center	168 West Main Street Springville, NY 14141

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review conducted during an Abbreviated Partial Extended survey (Complaint #NY00361768-437980), the facility failed to protect residents from abuse by staff for one (1) (Resident #1) of three (3) residents reviewed for abuse. Specifically, on 11/12/2024 Certified Nurse Aide #5 shared with co-workers, a live photograph (feature on a cell phone that captures a 1.5 to 3 second video with sound that allows a photo to come to life) that was taken on their personal cellphone, of Resident #1 during incontinence care with their buttocks exposed, and without the resident's consent. Using the reasonable person concept, as referenced on the Centers for Medicare and Medicaid Services Psychosocial Outcome Severity guide, it was determined psychosocial harm occurred for Resident #1 that is not -immediate Jeopardy. The finding is: The policy and procedure titled Abuse and Neglect - Clinical Protocol dated 03/2018, documented instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled using technology. The policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 04/2021 documented residents have the right to be free from abuse. This includes but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Establish and maintain a culture of compassion and care for all residents and particularly those with behavioral, cognitive or emotional problems; investigate and report any allegations within timeframes required by federal requirements. Resident #1 had diagnoses including dementia (progressive or persistent loss of intellectual functioning), major depression disorder (condition characterized by persistent feelings of sadness, hopelessness, and loss of interest), and anxiety disorder (mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). The Minimum Data Set (a resident assessment tool) dated 11/06/2024 documented Resident #1 was always understood, usually understands others and was severely cognitively impaired. The Comprehensive Care Plan, revised on 05/17/2021 documented Resident #1 had a mood problem related to diagnosis of bipolar disorder and a history of traumatic events of abuse when they were younger. Documented interventions included to approach in a cheerful manner, monitor, record, report to medical director as needed for mood patterns signs/symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. Additionally, it documented Resident #1 had diagnosis of anxiety, had periods of anxiousness, and weepiness. History of accusatory behavior. History of repetitive statement regarding their past. Documented interventions included to attempt to determine triggers that caused behavior. The facility Investigation Summary dated 11/25/2024 documented Resident #1 was found to be grossly incontinent; Certified Nurse Aide #2 went to provide care and became overwhelmed by odor and asked that Certified Nurse Aide #1 assist them. Certified Nurse Aide #2 began to cough and gag in Resident #1's room while Certified Nurse Aide #1 was attempting to assist. Resident #1 was standing with their walker while Certified Nurse Aide #1 was attempting to assist with cleaning Resident #1. Certified Nurse Aide #1 became overwhelmed by odor and began to gag and began telling Certified Nurse Aide #2 I quit, I quit. Certified Nurse Aide #5 whom was down the hallway heard Certified Nurse Aide #1 and went to the room. When Certified Nurse Aide #5 arrived at the room, they observed Certified Nurse Aide #1 and Certified Nurse Aide #2 gagging and laughing at each other while attempting to provide care and took a video/photograph (live photo) of the incident as they thought the staff's reactions were funny. This incident occurred the end of August or the beginning of September 2024. Certified Nurse Aide #5 on 11/12/2024 showed the video/photograph (live photo) to multiple staff, laughing at Certified Nurse Aide #1's reaction. While interviewing staff about the video/photograph (live photo), staff report observing a video which showed Resident #1 unclothed from the waist down, however, did not show Resident #1's face, yet they were certain it was Resident #1. Multiple staff reported the Assistant Director of Nursing was present, so they did not report the incident because they were aware of supervisor knowledge. During an interview on 11/06/2025 at 10:53 AM, Certified Nurse Aide #1 stated they recalled that they were assisting Certified Nurse Aide #2 with Resident #1's care and there was a strong odor in the room because Resident #1 had had a bowel movement. Certified Nurse Aide #1 stated it was overwhelming and there was feces all over Resident #1's buttocks and clothes. They remembered that Certified Nurse Aide #2 began gagging and they placed a clean

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review conducted during an Abbreviated Partial Extended survey (Complaint #NY00361768-437980) the facility did not ensure that all alleged violations involving abuse and mistreatment are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse, to other officials (including the State Survey Agency) for one (1) (Resident #1) of three (3) residents reviewed. Specifically, allegations of resident abuse identified by multiple staff members on 11/12/2024 was not reported to the Administrator until 11/25/2024. The allegation was not reported to the New York State Department of Health within two (2) hours which resulted in psychosocial harm for Resident #1, with the potential to affect all residents in the facility, that was substandard quality of care to resident health and safety that is not Immediate Jeopardy. The finding is: Refer to the additional Statement of Deficiencies (CMS Form-2567) for F 600 Freedom from Abuse and Neglect, scope and severity G. The policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 04/2021 documented all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. If resident abuse, neglect, exploitation is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports their suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying. Immediately is defined as within two (2) hours of an allegation involving abuse. Review of the Internet Quality Improvement and Evaluation System (iQIES) Report: Complaint/Incident/Investigation Report received on 11/25/2024 at 1:51 PM documented Certified Nurse Aide #3 reported to the Administrator that a staff member had a video on their phone involving a resident. Certified Nurse Aide #3 reported observing a video that involved two (2) staff members gagging and laughing while providing incontinence care to a resident. The facility Investigation Summary completed by the Director of Nursing, dated 11/25/2024, documented the alleged abuse was discovered on 11/23/2024, the time the Director of Nursing was notified was blank. The facility investigation documented Certified Nurse Aide #5 had taken a video/photograph of Certified Nurse Aide #1 with Resident #1 in the background. Resident #1 was unclothed from the waist down. The video/photograph was taken at the end of August or beginning of September 2024. On 11/12/2024, Certified Nurse Aide #5 had shown the video/photograph to multiple staff members. Multiple staff reported that the Assistant Director of Nursing was present, so they did not report the incident because they were aware of supervisor knowledge. During an interview on 11/06/2025 at 10:53 AM, Certified Nurse Aide #1 stated they were not aware that Certified Nurse Aide #5 had taken the live photograph (feature on a cell phone that captures 1.5 to 3 second video with sound that allows a photo to come to life) and had found out about the photo a lot later. When they saw the photo, they did not see Resident #1 in the background, they only saw themselves. Certified Nurse Aide #1 stated they did not report the picture because they did not see any residents in it. During an interview on 11/06/2025 at 11:04 AM, Certified Nurse Aide #2 stated they recalled Certified Nurse Aide #5 knocking on the door and coming into the room with their phone in their hand, but they were unaware that they had taken any video or photograph. They also stated that had not viewed the live photo. During a telephone interview on 11/06/2025 at 11:12 AM, Licensed Practical Nurse #1 stated Certified Nurse Aide #3 told them they had viewed a photo/video exposing Resident #1's buttocks. Licensed Practical Nurse #1 stated they never saw the video but had told Certified Nurse Aide #3 to report it to the supervisor, Director of Nursing and Administrator immediately. They stated Certified Nurse Aide #3 had expressed to them that they were intimidated by the Assistant Director of Nursing and were afraid of retaliation from them if they reported it. Licensed Practical Nurse #1 stated they did not report what Certified Nurse Aide #3 told them (about the Assistant Director of Nursing) because they did not think the Director of Nursing or Administrator would follow up on the incident. During a telephone interview on 11/06/2025 at 12:44 PM, Licensed Practical Nurse #2 stated in November of 2024 (could not recall exact date) Certified Nurse Aide #5 was showing a live photograph to Certified Nurse Aide #3 on the porch of the facility. Licensed Practical Nurse #2 stated when they looked over, they saw a video of Certified Nurse Aide #1 in a resident room. In the background they could see Resident #1's buttocks. This was bothersome to them, so they turned around and went back into the facility. They stated it was a form of abuse. Licensed Practical Nurse #2 stated that since the Assistant Director of Nursing was standing next to them, they saw the live