STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335785	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Finger Lakes Center for Living	20 Park Avenue Auburn, NY 13021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observations, record review, and interviews during the abbreviated survey (NY00381595), the facility did not ensure allegations of abuse and neglect were thoroughly investigated for 4 of 4 residents (Residents #1-4) reviewed. Specifically, the facility investigation was not thorough and did not identify concerns related to: -Resident #1's roommate (Resident #2) alleged on 5/19/2025 Certified Nurse Aides #1 and 2 yelled at Resident #1 while providing care. There was no documentation Resident #1 was assessed by a qualified professional, Certified Nurse Aides #1 and 2 continued to work at the facility after the allegation was made, and there was no documentation the Administrator was notified of the allegation. -Resident #2 reported on 5/19/2025, they developed a headache due to Certified Nurse Aides #1 and 2 yelling at Resident #1 and they (Resident #2) required a pain-relieving medication for the headache. There was no documentation Resident #2 was assessed by a qualified professional. - Certified Nurse Aide #6 reported while they provided care to Resident #3 on 5/19/2025, Certified Nurse Aides #1 and 2 yelled and used profanities in Resident #3's room, and Resident #3 was upset by the incident. There was no documentation Resident #3 was assessed by a qualified professional. -Resident #4 shared a room with Resident #3 and was in the room at the time of the incident on 5/19/2025 and there was no documentation Resident #4 was assessed by a qualified professional. Additionally, the incidents were not reported timely to the New York State Department of Health as required. Findings include: (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/2025 facility policy, Abuse Policy-Prevention and Management documented the Shift Supervisor was responsible for immediate initiation of the reporting process. The Administrator, Director of Nursing, and Risk Manager, if applicable, were responsible for investigation and reporting. The facility provided for the immediate safety of the resident upon identification of suspected abuse. They examined the alleged victim for signs of injury, including physical exam or psychosocial assessment if needed. The facility would begin the investigation process immediately and the findings recorded in the resident's record. The Administrator, Director of Nursing/designee were responsible for completion of investigative paperwork, interviewing persons reporting the incident, interviewing witnesses, interviewing the resident and resident roommate and interviewing other residents to which the accused employee provided care/services. Any time an allegation involving abuse that named a specific employee, the employee was suspended until the completion of the investigation. The employee was not to remain on duty and was not to be assigned to any other area of the facility. The facility reported abuse timely within the Federal/State requirements. Resident #1 had diagnoses including Alzheimer's disease. The 5/8/2025 Minimum Data Set assessment documented the resident's cognition was severely impaired. Resident #2 had diagnoses including anxiety and depression. The 5/7/2025 Minimum Data Set assessment documented the resident's cognition was intact. Resident #3 had diagnoses including chronic heart failure. The 5/8/2025 Minimum Data Set assessment documented the resident's cognition was intact. Resident #4 had diagnoses including dementia. The 2/26/2025 Minimum Data Set Assessment documented the resident's cognition was severely impaired. Statements completed on 5/19/2025 documented: -Licensed Practical Nurse #3 was told by Resident #2 Certified Nurse Aides #1 and 2 were yelling at Resident #1 during care and the yelling gave Resident #2 a headache. The curtains were left open during care and Resident #2 witnessed the incident. Resident #2 was given pain reliever and Licensed Practical Nurse #3 reported Resident #2's statement to Registered Nurse Supervisor #4. - Certified Nurse Aide #6 was in the bathroom providing care to Resident #3 when Certified Nurse Aides #1 and 2 entered the room and began cursing and talking loud about another resident. The three aides exited the room into the hall where Certified Nurse Aide #1 continued to talk loudly and told Licensed Practical Nurse #7 they would quit their job. Resident #3 later reported to Certified Nurse Aide #3 they were upset by the incident with the aides and Licensed Practical Nurse #7 and Registered Nurse Supervisor #4 were notified. There was no evidence of staff statements from Certified Nurse Aides #1 or 2, or from Licensed Practical Nurse #7 on 5/19/2025. The 5/19/2025 at 10:16 PM Medication Administration Record documented Resident #2 received acetaminophen (pain reliever) 650 milligrams for headache. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/19/2025 at 10:50 PM Registered Nurse Supervisor #4's email to the Director of Nursing documented Licensed Practical Nurse #3 reported Resident #2 complained about Certified Nurse Aides #1 and 2 and they left Licensed Practical Nurse #3's statement for the Director of Nursing to review. Certified Nurse Aide #6 overheard Certified Nurse Aides #1 and 2 using foul language in Resident #3's room and Resident #3 was upset. Licensed Practical Nurse #7 overheard conversations between Certified Nurse Aides #1 and 2 and they would provide a statement. There was no documented evidence of a statement provided by Licensed Practical Nurse #7. There was no documented evidence Registered Nurse Supervisor #4 assessed Residents #1, 2, 3 or 4 (roommate of Resident #3 present in the room during the incident) after the incidents, no evidence Certified Nurse Aide #1 and 2 were suspended, and the incident was not reported to the Administrator. Certified Nurse Aide #1's timesheet documented they worked at the facility on 5/21 and 5/22/2025. Certified Nurse Aide #2's timesheet documented they worked at the facility 5/20, 5/21, 5/22 and 5/23/2025. On 5/24/2025, Certified Nurse Aide #1 was terminated. Certified Nurse Aide #2 continued to work at the facility. The 5/27/2025 at 4:39 PM Director of Social Services note documented on 5/23/2025, they received an email from the family of Resident #1 with concerns Resident #1 was involved in an incident with suspicion of abuse. The Director of Social Services was not informed of any incident prior to receipt of the email. Information from resident interviews they completed on 5/23/2025 included: - Resident #2 reported their roommate (Resident #1) was being provided care by Certified Nurse Aide #1 and an unknown aide (later identified as Certified Nurse Aide #2). Resident #2 witnessed the incident because the curtain was left open. Resident #1 was not being cooperative and Certified Nurse Aide #1 was being aggressive with turning and lifting the resident, pushing on the resident and lifting them off the bed. Profanities were used by Certified Nurse Aide #1. - Resident #1 was not able to recall details of the incident. - Resident #3 reported their aide (Certified Nurse Aide #6) was caring for them and 2 other aides came in their room and were swearing while talking to their aide. Resident #3 stated they were not swearing at them (Resident #3) but having a conversation about others and swearing and talking. The 5/27/2025 Certified Nurse Aide #2's statement (8 days after the incident) documented on 5/19/2025, they were providing care to Resident #1 with Certified Nurse Aide #1 when they (Certified Nurse Aide #2) accidentally said a curse word two times. They knew they should not have cursed and turned themselves in to the Director of Nursing the following day. They never cursed in Resident #3's room and Certified Nurse Aide #1 cursed in Resident #3's room. Certified Nurse Aide #2's statement did not document what they observed during care with Resident #1 and Certified Nurse Aide #1 on 5/19/2025. On 5/29/2025, Registered Nurse Managers and Supervisors received education regarding abuse reporting and the New York State Incident Reporting Manual. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/2025, Resident #1 was observed in their wheelchair in their room. The resident smiled when asked questions, did not respond to questions when asked, and appeared confused. On 5/30/2025, Certified Nurse Aide #2 received counseling regarding using inappropriate language. During an interview on 6/2/2025 at 9:20 AM, Resident #2 stated they did not recall the date of the incident. The curtain was open between their bed and Resident #1's bed while Certified Nurse Aide #2 and an unknown aide (Certified Nurse Aide #1) provided care to Resident #1. When the aides were changing Resident #1, the aides seemed rough, lifting the resident up. The aides were cursing, and Resident #1 seemed agitated. They (Resident #2) requested acetaminophen because they had a headache from all the yelling. They had conversations regarding the incident including the social worker and the Director of Nursing a couple of days after the incident. During an interview on 6/2/2025 at 10:15 AM, Certified Nurse Aide #2 stated on 5/19/2025, they and Certified Nurse Aide #1 were providing incontinence care to Resident #1. When they rolled the resident over, they pulled a muscle in their back and said a curse word out loud. The curse was not directed at the resident. They did not recall exactly what Certified Nurse Aide #1 said during care, however they were typically a loud talker and they were cursing about something not related to the resident. They did not report their own inappropriate language until the next day when they self-reported to the Director of Nursing they used foul language in the resident's room. They could not recall why they completed their statement 8 days after the incident. During an interview on 6/2/2025 at 12:45 PM, Certified Nurse Aide #6 stated on 5/19/2025 around 7:30 PM, they were assisting Resident #3 in the bathroom. Certified Nurse Aides #1 and 2 entered Resident #3's room and were yelling and cursing about something unrelated to Resident #3. Certified Nurse Aide #6 told the aides to leave the room. After they left the room, Licensed Practical Nurse #7 heard Certified Nurse Aide #1 cursing and told them they were being unprofessional. Licensed Practical Nurse #7 also spoke with Certified Nurse Aide #2. Licensed Practical Nurse #7 reported the incident to Registered Nurse Supervisor #4. During an interview on 6/2/2025 at 1:12 PM, Licensed Practical Nurse #3 stated on 5/19/2025, Resident #2 rang their call bell, asked for acetaminophen and said they had a bad headache. Licensed Practical Nurse #3 thought the resident looked upset and asked what was wrong. The resident reported 2 aides were providing care to Resident #1, they did not pull the privacy curtain, and they were screaming at Resident #1 because Resident #1 was not cooperating. Resident #2 did not allege any physical abuse and only discussed privacy concerns and yelling. Licensed Practical Nurse #3 reported the conversation with Resident #2 to Registered Nurse Supervisor #4 and asked them to see Resident #2. It was towards the end of shift, and they did not believe the supervisor saw the resident. Registered Nurse Supervisor #4 asked Licensed Practical Nurse #3 to provide a statement. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/2/2025 at 3:05 PM, Registered Nurse Supervisor #4 stated on 5/19/2025 around 7 PM, they assessed Resident #3 after the resident alleged Certified Nurse Aides #1 and 2 were cursing in their room (there was no documented evidence of an assessment). Around 10:50 PM, they were notified by Licensed Practical Nurse #3 that Resident #2, who was alert and oriented, heard 2 aides using foul language while providing care to Resident #1. They did not assess Resident #1 or 2 because it was the end of their shift. They did not suspend the aides because they were not sure if they could suspend them. They sent a text message and email the Director of Nursing that night regarding the incidents and thought by morning, the Director of Nursing would be aware and address the situation accordingly. On 6/3/2025 at 2 PM, Certified Nurse Aide #1 was not reached in an interview. During an interview on 6/4/2025 at 9:15 AM the Director of Nursing stated when an abuse allegation was made, the resident needed to be assessed, an incident report started, statements obtained immediately, and accused staff suspended. The Administrator would be notified of the allegation. They first became aware of the incident on 5/20/2025 when they received a vague email from Registered Nurse Supervisor #4 and a few statements that they reviewed from staff. They read the staff statements and immediately forwarded the email and statements to their Human Resources Department. They spoke with Resident #2 that morning who gave a very different report. Resident #2's main concern was Resident #1 being put to bed early at 6:30 PM on 5/19/2025. Resident #2 reported the aides were swearing while providing care to Resident #1 though the swearing was not directed at the resident. Nothing Resident #2 stated to the Director of Nursing seemed abusive. They asked Resident #2 about the curtain not being pulled and they stated the curtain was pulled but when the aides were moving about the room, and the curtain moved enough to see the incident. The Director of Nursing stated when Resident #1 was resistive to care, the aides should have left the room and reapproached later. When Resident #2 developed a headache from the aides yelling in their room, they did not consider that abuse and when they interviewed Resident #2, the resident did not report this to them. Resident #1 should have been assessed on 5/19/2025 by Registered Nurse Supervisor #4 when the allegation of abuse was made. Resident #3 should have also been assessed for the reaction they had to the aides cursing in their room. They were not aware any of the residents were not assessed. In retrospect, they (the Director of Nursing) should have notified the Administrator of the incident and they did not. All registered nurses were re-educated on the abuse reporting process. When the email of abuse from Resident #1's family was received on 5/23/2025, that was when the Administrator became aware. They were aware Certified Nurse Aide #2 continued to work and Certified Nurse Aide #2 was given a directive to not work with Resident #1. Both Certified Nurse Aide #1 and 2 should have been suspended on 5/19/2025. They did not remove the staff when they became aware of the incident on 5/20/2025 because they were going by Human Resources directives. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/2025 at 9:45 AM, the Administrator stated they expected to be notified when there was an allegation of abuse, and they would notify the Department of Health within 2 hours. Resident assessments were needed as well as staff statements and any accused staff suspended. On 5/23/2025, they first became aware of the incident when it was reported an email was received from Resident #1's family regarding abuse. They filed a report with the Department of Health on 5/23/2025. On 5/19/2025, Registered Nurse Supervisor #4 should have contacted them about the incidents and did not. They would have directed them to gather statements, and the accused staff would have been suspended. When they became aware of the incident on 5/23/2025, they felt Certified Nurse Aide #1 verbally abused Resident #1. Resident #2 reported Certified Nurse Aide #2 did not curse and the Administrator did not consider suspension at that time. When Resident #1 became agitated with care on 5/19/2025, both Certified Nurse Aides #1 and 2 should have stopped and reapproached and they did not do that. They were not sure if Certified Nurse Aide #2 was re-educated about reapproaching when a resident was agitated with care. They stated the facility did not thoroughly investigate the incidents, the incident was not investigated timely, and it was not reported timely. During an interview on 6/4/2025 at 2:10 PM, Resident #3 stated they were not afraid when the incident occurred with Certified Nurse Aides #1 and 2 however, they did not feel good about it. Their roommate (Resident #4) was also in the room at the time of the incident. On 6/4/2025 at 2:13 PM, Resident #4 was observed in their bed across from Resident #3. The resident was unable to respond to questions. 10NYCRR 415.4(b)(2-3)