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	06/30/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review and interviews during the abbreviated survey (NY00383652), the facility did not ensure one (1) of three (3) residents (Resident #1) reviewed received their needed respiratory care. Specifically, Resident #1 had a medical order for oxygen at bedtime, and on 6/13/2025 their oxygen tubing with the nasal cannula was not applied as ordered by Licensed Practical Nurse #3. This resulted in a decrease in Resident #1's oxygen saturation, and they were subsequently transferred to the emergency department to be evaluated for their respiratory distress. Findings include: The 3/6/2025 facility policy, Oxygen Administration, documented the nurse should: - verify a physician's order for oxygen before administration of oxygen; - assess for signs and symptoms of cyanosis (skin, nails and lips turn a blue color due to lack of oxygen in the blood) and hypoxia (low levels of oxygen in body tissues that can cause confusion and difficulty breathing); - check to make sure oxygen tubing was connected to the oxygen source and oxygen turned on; and - place appropriate oxygen delivery device (nasal cannula, mask) on the resident. Resident #1 was admitted with diagnoses including pneumonia and cerebral vascular accident (CVA). The 5/16/2025 Minimum Data Set assessment documented the resident had moderate cognitive impairment, required partial to moderate assistance with personal hygiene and sit to lying, required substantial to maximal assistance to roll left to right, was dependent for sit to stand, was on an antibiotic and used a wheelchair. The resident did not use oxygen therapy. A Physician's Order on 6/10/2025 documented to obtain and send sputum sample, overnight oximetry (non-invasive measurement for oxygen saturation level in the blood) due to hypoxia on room air, and oxygen at 2 liters/minute via nasal cannula for shortness of breath at bedtime. The Comprehensive Care Plan, effective date 6/10/2025 and revised 6/17/2025 documented the resident had pneumonia, and interventions included monitor vital signs as ordered, evaluate for shortness of breath, chest pain and discomfort with breathing or coughing, and administer prescribed antibiotics. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/13/2025 Medication Administration Record for oxygen at 2 liters/minute via nasal cannula applied at bedtime was signed as administered by Licensed Practical Nurse #3 at 9:38 PM. A nursing progress note on 6/13/2025 at 10:41 PM by Licensed Practical Nurse #3 documented antibiotics complete, no complaints voiced, condom catheter on, temperature 97.6 degrees Fahrenheit and oxygen saturation 95%. A Physician's Order on 6/14/2025 at 12:10 AM documented to send resident to emergency department for respiratory distress. A nursing progress note on 6/14/2025 at 12:41 AM by Registered Nurse Supervisor #6 documented resident experienced shortness of breath, oxygen saturation was 54% on room air, oxygen increased to 6 liters/minute via nasal cannula, breathing treatment administered and oxygen saturation increased to 80%. The family representative was called and resident was transferred to the emergency department. The facility incident report, dated 6/14/2025, documented: The incident involving Resident #1 occurred at 12:10 AM. The resident was found in their bed short of breath in respiratory distress, without their nasal cannula on, but the tubing was attached to the oxygen regulator on the wall. Their oxygen saturation at the time was 54% and their face was gray in color. Oxygen was increased to 6 liters/minute and a nebulizer was applied. They were coughing up blood-tinged sputum and were unable to speak. The resident was then placed with a non-rebreather mask after the other interventions were attempted and their oxygen saturation did not improve. The resident's representative was notified and medical was notified, and the resident was transported to the emergency department (in the same building as the nursing home). The Emergency Department admission Report dated 6/14/2025 at 12:27 AM documented Resident #1 presented at the emergency department for evaluation due to having an oxygen saturation on room air of 54% and coughing up blood-tinged sputum after receiving a breathing treatment. The resident was currently being treated for aspiration pneumonia. During an interview on 6/26/2025 at 11:50 AM Licensed Practical Nurse #3 stated they were the medication nurse on the evening shift of 6/13/2025 (3 PM - 11 PM). They were not sure what time Resident #1 was put to bed. The resident's oxygen order was to apply oxygen at 2 liters/minute via nasal cannula at bedtime. On the evening of 6/13/2025 they recalled applying the resident's condom catheter (urine collection device) while they were in bed, but they could not recall what time that was or if the resident was wearing their oxygen at that time. The resident was not in respiratory distress when they applied their condom catheter; if they had been, they would have done something about it. No staff approached them about the resident being in respiratory distress. They gave report to oncoming Licensed Practical Nurse #5 and left their shift at 11:00 PM. They were told the next day they were suspended from work pending the facility investigation. They returned to work on Monday, 6/23/2025, and received re-education on oxygen administration and medication administration. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 6/26/2025 at 1:04 PM Licensed Practical Nurse #3 restated they could not remember putting Resident #1's nasal cannula on them and turning on the oxygen 6/13/2025. They would know if a resident needed oxygen because it was a medical order and would be documented in the Medication Administration Record (on the computer on the medication cart). The oxygen was on a wall regulator with the oxygen tubing plugged into a port on the wall, and there was a button to push to get the oxygen flowing. Certified Nurse Aides were not supposed to touch the oxygen. During a disciplinary meeting on 6/18/2025 with Human Resources they were told they (Licensed Practical Nurse #3) had signed for Resident #1 wearing their oxygen on 6/13/2025 at 9:38 PM but the resident was found by night shift staff not wearing their nasal cannula, which resulted in them not receiving oxygen and in respiratory distress. They stated they typically would apply the oxygen at the same time as applying the resident's condom catheter. It was a very busy shift on 6/13/2025. During an interview on 6/26/2025 at 4:06 PM Certified Nurse Aide #4 stated they worked the night shift on 6/14/2025 (11:00 PM - 7:00 AM). They were doing their first rounds on the unit when, around midnight, they found Resident #1 in respiratory distress. The resident was sitting up in their bed, but they could not remember if the resident was wearing their oxygen tubing with nasal cannula or not. They notified Licensed Practical Nurse #5 about Resident #1's respiratory distress. A few minutes later they saw Registered Nurse Supervisor #6 go into the resident's room with Licensed Practical Nurse #5 to assess the resident. During an interview on 6/27/2025 at 3:58 PM Registered Nurse Supervisor #6 stated on the night of 6/14/2025 they were in another resident room when Certified Nurse Aide #4 was calling out for help with Resident #1 and stating they were not breathing right. They brought the vital signs machine to Resident #1's room because they remembered a week earlier the resident had a similar episode with respiratory distress, and the resident currently had a diagnosis of pneumonia. When they got to the room the resident was struggling to breathe. When they checked the resident's oxygen saturation it was 54% on room air. They reached for the resident's nasal cannula and oxygen tubing which were tangled and on top of the oxygen humidifier and regulator on the wall. The oxygen and humidifier were not turned on. They turned on the dial to the regulator and it was in working condition. They turned the oxygen to 2 liters/minute. At the time they did not know what the resident's oxygen orders were and 2 liters/minute was the normal starting rate. When the 2 liters of oxygen did not improve the resident's breathing they increased the oxygen to 6 liters/minute and had Licensed Practical Nurse #5 start a breathing treatment for the resident. After that, they applied a non-rebreather mask and called the emergency department on the phone right outside the resident's room. They had been instructed by the facility if a resident was in respiratory distress to call the emergency department immediately to let them know a resident was being transported to them. They called the resident's family representative and informed them of the resident's transport to the emergency department. They called the on-call Medical Provider after the emergency department transport to inform them of the situation. Licensed Practical Nurse #3 was probably very busy during their shift, had many interruptions, and forgot to apply the oxygen to Resident #1. During an interview on 6/27/2025 at 4:55 PM the Director of Nursing stated during the facility investigation of the 6/14/2025 incident, they obtained a verbal statement from Licensed Practical Nurse #3 admitting to signing for the administration of oxygen but forgetting to apply the oxygen tubing and nasal cannula on the resident and turning the oxygen on. Licensed Practical Nurse #3 had signed for applying both the condom catheter and oxygen on 6/13/2025 at 9:38 PM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 6/30/2025 at 11:09 AM they stated they were first notified of the incident with Resident #1 on 6/14/2025 at 2:20 AM by a text message from Registered Nurse Supervisor #6. Licensed Practical Nurse #3 forgot to put the nasal cannula on the resident and turn the oxygen on; they had many things going on that shift. Licensed Practical Nurse #3 was suspended from work in the morning on 6/14/2025 pending the facility investigation, and had re-education of oxygen and medication administration when they returned to work. Resident #1 had recurring aspiration pneumonia and had been on several courses of antibiotics prior to the 6/14/2025 incident. Resident #1 was re-admitted back to the facility on 6/18/2025 with a diagnosis of pneumonia. 10 NYCRR 415.12(k)(6)