| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335785 | A. Building<br>B. Wing | 10/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Finger Lakes Center for Living | 20 Park Avenue<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on record review and interviews during the abbreviated survey (#2626859) the facility did not ensure a significant medication error was reported to the State Agency as required for one (1) of five (5) residents (Resident #1) reviewed. Specifically, Resident #1's hospital discharge medications included an anticoagulant (blood thinner), the medication was not ordered upon admission to the facility, and the resident did not receive an anticoagulant from 9/2/2025 - 9/18/2025. Resident #1 was subsequently sent to the hospital and diagnosed with deep vein thrombosis (a blood clot in a vein). The facility did not report the incident to the New York State Department of Health in the required time frame.Findings include:The August 2016 New York State Department of Health Incident Reporting Manual documented neglect as the failure to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care to a resident of a residential health care facility while the resident is under the supervision of the facility. Neglect may include but is not limited to failure to carry out physician orders, medication omission, treatment omission or failure to follow the care plan or provide emergency services.The facility policy Abuse Policy-Prevention and Reporting, revised 6/2025, documented the facility would begin the investigation process immediately upon notification of the incident and would prevent further abuse, neglect, exploitation, or mistreatment while the investigation was ongoing. The Administrator, Director of Nursing, or designee would notify the appropriate Agency/ State office according to State specific guidelines for timeliness of reporting as applicable. Resident #1 had diagnoses including fractures of the left femur (thigh bone) and left humerus (arm bone), and dislocation of the left shoulder joint. The 9/9/2025 Minimum Data Set assessment (an assessment tool) documented the resident was cognitively intact and did not receive an anticoagulant on admission or while a resident at the facility.The 09/02/2025 Hospital Discharge Summary documented the resident was admitted to the hospital with a hip fracture and would be discharged to a skilled nursing facility for rehabilitation. The discharge medication list included Eliquis (anticoagulant) 2.5 milligrams twice daily.The 9/2/2025 Hospital Discharge Medication Reconciliation Order Report documented Eliquis 2.5 milligrams twice daily.A 9/2/2025 at 1:28 PM, Registered Nurse #3 progress note documented Resident #1 was admitted to the facility at 12:10 PM with a diagnosis of left femoral fracture, there was no noted edema (swelling) to their bilateral lower extremities, and the medication reconciliation was completed with Nurse Practitioner #4.A 9/2/2025 at 2:27 PM, Nurse Practitioner #4 progress note documented the resident was admitted to the facility for short term rehabilitation for a fracture of the left femur. The assessment and plan included Eliquis 2.5 milligrams twice daily.There was no documented evidence an anticoagulant was ordered upon admission to the facility. A 9/3/2025 at 2:37 PM, Registered Nurse #3 progress note documented the resident's baseline care plan was reviewed with the resident and they left a copy of the medication list at the resident's bedside.A 9/18/2025 at 11:12 AM, Registered Nurse Manager #15 progress note documented the resident was transferred to the emergency room from their orthopedic specialist appointment for an ultrasound due to edema in the lower extremity.The 09/25/2025 Nursing Home Investigative Report submitted to the New York State Department of Health documented Resident #1 was seen for a follow-up Orthopedic appointment, complained of edema in their leg and was sent to the hospital and diagnosed with deep vein thrombosis. Through investigation it was discovered Registered Nurse #3 did ask for clarification when they had questions regarding the resident's anticoagulant orders documented on the hospital medication reconciliation order report.There was no documented evidence the significant medication error was reported to the New York State Department of Health within the required time frame.During an interview on 10/17/2025 at 10:39 AM the Director of Nursing stated they were made aware by Nurse Practitioner #1 on 09/19/2025, Resident #1 had not received any anticoagulant medication and developed a deep vein thrombosis. They alerted the facility Administrator and the discharging hospital's Risk Management Team of the incident. The facility started an investigation when they were notified by the hospital.During a follow up interview with the Director of Nursing on 10/17/2025 at 11:53 AM, they stated the facility's Administrator was responsible for reporting incidents to the New York State Department of Health and was unsure when the incident was reported. During an interview with the facility's Administrator on 10/20/2025 at 2:25 PM, they stated it was their responsibility to report incidents to the New York State Department of Health. They referred to the New York State Department of Health Incident Reporting Manual to determine what incidents to report. They stated any incidents of abuse and neglect, which resulted in physical harm should be reported within 2 hours of being them being notified and 24 hours if there was no physical harm to the resident. The Director of Nursing and |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the abbreviated survey (IQIES #2626859), the facility failed to ensure residents were free from significant medications errors for one (1) of five (5) residents (Resident #1) reviewed for admission orders. Specifically, Resident #1's hospital discharge medications included an anticoagulant (blood thinner). The medication was not ordered upon admission, and the resident did not receive an anticoagulant from 09/02/2025 - 09/18/2025. Resident #1 was subsequently sent to the hospital and diagnosed with a deep vein thrombosis (a blood clot in a vein). This resulted in actual harm to Resident #1 and the likelihood of serious injury, serious harm, serious impairment, or death that was Immediate Jeopardy and Substandard Quality of Care to resident's health and safety for all residents with potential admission/readmission orders.Findings include:The facility policy Medication Ordering, revised 05/07/2025, documented all medication orders were transcribed into the resident's Medication Administration Records, the medication must include drug name, dosage, route, frequency, start date, and prescriber, and changes to orders must be documented promptly and verified by nursing.The facility policy Medication Transcription, revised 09/15/2025, documented all medication must be transcribed accurately and promptly into the resident's Medication Administration Record by licensed nursing personnel. Transcription must reflect the prescriber's intent. Orders must be received from a licensed prescriber, verbal orders must be transcribed immediately and continued by and countersigned by the prescriber within 48 hours. Electronic orders were reviewed for completeness and clarity. Orders were transcribed exactly as written, including drug names, dosage, route, frequency, and duration. The double check protocol included a second nurse would verify transcriptions of high-risk medications, which included anticoagulants, and any discrepancies would be resolved before administration. All nursing staff would report concerns or errors to the Director of Nursing immediately.The facility policy Anticoagulant Therapy, revised 09/2025, documented anticoagulants were prescribed by a licensed practitioner with appropriate clinical justification. Double check protocols would be followed for high-risk medications and administration times and dosages would match the prescriber's orders exactly.Resident #1 had diagnoses including fractures of the left femur (thigh bone) and left humerus (arm bone), and dislocation of the left shoulder joint. The 09/09/2025 Minimum Data Set assessment (a resident assessment tool) documented the resident was cognitively intact and did not receive an anticoagulant on admission or while a resident at the facility.The 09/02/2025 Hospital Discharge Summary documented the resident was admitted to the hospital with a hip fracture and would be discharged to a skilled nursing facility for rehabilitation. The discharge medication list included Eliquis (anticoagulant) 2.5 milligrams twice daily.The 09/02/2025 Hospital Discharge Medication Reconciliation Order Report documented Eliquis 2.5 milligrams twice daily.A 09/02/2025 at 1:28 PM progress note by Registered Nurse #3, documented Resident #1 was admitted to the facility at 12:10 PM with a diagnosis of left femoral fracture, there was no noted edema (swelling) to their bilateral lower extremities, and the medication reconciliation was completed with Nurse Practitioner #4.A 09/02/2025 at 2:27 PM progress note by Nurse Practitioner #4, documented the resident was admitted to the facility for short term rehabilitation for a fracture of the left femur. The assessment and plan included Eliquis 2.5 milligrams twice daily.There was no documented evidence an anticoagulant was ordered upon admission to the facility.A 09/03/2025 at 2:37 PM progress note by Registered Nurse #3, documented the resident's baseline care plan was reviewed with the resident and they left a copy of the medication list at the resident's bedside.A 09/18/2025 at 11:12 AM progress note by Registered Nurse Manager #15, documented the resident was transferred to the emergency room from their orthopedic specialist appointment for an ultrasound due to edema (fluid build-up) in the lower extremity.The 09/25/2025 Nursing Home Investigative Report submitted to the New York State Department of Health documented Resident #1 was seen for a follow-up orthopedic appointment, complained of edema in their leg and was sent to the hospital and diagnosed with a deep vein thrombosis. Through investigation, it was discovered Registered Nurse #3 did not follow up when they had questions regarding the resident's anticoagulant orders documented on the hospital medication reconciliation order report.During an interview on 10/15/2025 at 3:13 PM, Registered Nurse #3 stated they were the admissions nurse on 09/02/2025 as the regular admission nurse was off. Resident #1 was scheduled to be admitted to the facility that day. On 09/02/2025, prior to the arrival of the resident, they accessed the resident's hospital records. At that time, the Hospital Medication Reconciliation Order Form was marked as completed and the Discharge Summary was not available. When |