

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335785	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2026
NAME OF PROVIDER OR SUPPLIER  Finger Lakes Center for Living		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during a survey (IQIES #2733288), the facility failed to implement immediate measures to protect residents from abuse for two (2) of four (4) residents (Residents #1 and #2) reviewed. Specifically, there was witnessed verbal and physical abuse by Certified Nurse Aide #7 toward Resident #1. Certified Nurse Aide #7 continued to have access to residents, resulting in an incident of verbal abuse with Resident #2. There was no documented evidence that a registered nurse completed assessments on Resident #1 or Resident #2 on [DATE] after the incidents of witnessed abuse. Specifically:-On [DATE] at approximately 4:00 PM, Certified Nurse Aide #9 witnessed Certified Nurse Aide #7 handling Resident #1 roughly, spraying them with perfume when they were combative with care, and making a verbally abusive statement. Certified Nurse Aide #9 reported the incident to Registered Nurse Supervisor #12, who did not assess Resident #1. Certified Nurse Aide #7 continued to have access to residents, and after supper, Certified Aide #7 made a verbally abusive statement to Resident #2, which was witnessed by Certified Nurse Aide #10. There was no registered nurse assessment, and Certified Nurse Aide #7 continued to have access to residents. Certified Nurse Aide #7 was sent home on suspension at 8:00 PM. The facility's failure to protect residents from abuse resulted in potential for harm that is Immediate Jeopardy and Substandard Quality of Care and places all 74 residents in the facility at risk for the likelihood of serious injury, serious harm, serious impairment, or death. Findings include: The facility Abuse Policy - Prevention and Reporting, revised 06/2025, documented when a facility had identified abuse they must take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. Examples of verbal abuse included mocking, insulting, harassing, yelling or hovering over the resident with the intent to intimidate, and threatening the resident. Examples of physical abuse included hitting, slapping and holding the resident roughly. Protection for residents of suspected abuse included: provide for the immediate safety of the resident upon identification of suspected abuse; respond immediately to protect the alleged victim and integrity of the investigation; examine the victim for any sign of injury including a physical examination or psychosocial assessment if needed; increased supervision of the alleged victim and residents; and immediate suspension of the suspected employee pending the outcome of the investigation. 1) Resident #1 had diagnoses including aphasia (difficulty speaking), hemiplegia (one-sided paralysis), and anxiety disorder. The [DATE] Minimum Data Set (a resident assessment tool) documented that the resident had severely impaired cognition, used a wheelchair, had limited range of motion in one leg and arm, and required substantial to maximal assistance for most activities of daily living. The Facility Accident/Incident Report completed by the Director of Nursing on [DATE], documented on [DATE]:-Licensed Practical Nurse #13 was taking their lunch break (time later identified as approximately 7:30 PM) when Certified Nurse Aide #8 told them Certified Nurse Aide #7 sprayed perfume in Resident #1's face (witnessed occurrence was 4:00 PM).-The Director of</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335785
		If continuation sheet Page 1 of 8

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Nursing was notified (by phone) of the incident by Licensed Practical Nurse #13 at 7:49 PM. Certified Nurse Aide #7 was suspended from work (time later identified as approximately 8:00 PM).-A registered nurse assessment of Resident #1 was completed by the Director of Nursing on [DATE] at 7:30 AM.-Nurse Practitioner #16 was notified of the incident by the Director of Nursing on [DATE] at 10:00 AM.-Resident #1's family representative was notified of the incident by the Administrator on [DATE] at 6:00 PM. There was no documented evidence that a registered nurse assessment was completed for Resident #1 and Resident #2 on [DATE] immediately after the incidents occurred. Certified Nurse Aide #7 was not immediately relieved of duty after the witnessed abuse of Resident #1 at 4:00 PM on [DATE] and continued to have access to residents until approximately 8:00 PM. During a phone interview on [DATE] at 1:28 PM, Certified Nurse Aide #8 stated on [DATE] at 4:00 PM they and Certified Nurse Aide #7 were getting Resident #1 cleaned up before supper. Resident #1 was being combative with care. They stated out of their peripheral vision they saw Certified Nurse Aide #7 spray Resident #1 with perfume what they thought was over their head several times. A co-worker, Certified Nurse Aide #9 came into the room and offered to help. Certified Nurse Aide #9 told them they saw Certified Nurse Aide #7 spray Resident #1 with perfume. They told Certified Nurse Aide #9 they needed to report the incident to Registered Nurse Supervisor #12. Certified Nurse Aide #9 left to report the incident to Registered Nurse Supervisor #12 at approximately 4:45 PM. When Certified Nurse Aide #9 came back to the unit, they told them Registered Nurse Supervisor #12 would speak with them about the incident after supper. Registered Nurse Supervisor #12 left at 7:00 PM (when their shift was done) and never spoke with them about the incident. During Licensed Practical Nurse #13's supper break, they told them about the incident with Resident #1 and how Registered Nurse #12 never spoke with them about the incident. They did not know why Certified Nurse Aide #7 was still working after the incident. Licensed Practical Nurse #13 called the Director of Nursing and was given instructions to send Certified Nurse Aide #7 home on suspension. Certified Nurse Aide #7 was sent home at approximately 8:00 PM. Certified Nurse Aide #7 had resident assignments on both halls of the unit the evening of [DATE]. At the time of the incident that evening they had not heard anything about an incident involving Resident #2. Resident #2 resided on the other hall. During a phone interview on [DATE] at 10:37 AM, Certified Nurse Aide #7 stated on [DATE] during the evening shift they were assisting Certified Nurse Aide #8 with Resident #1's care. Resident #1 was combative with care, so they tried to, play word games to distract the resident. Certified Nurse Aide #9 came into the room to assist with Resident #1's care because they had a few minutes, as their resident was on the commode. They told Certified Nurse Aide #9 to, Please get your resident off the commode, they could die on the commode. Once they got Resident #1 into their wheelchair, they sprayed perfume on their body because, That was what they usually did after they got them cleaned up. They were told by Licensed Practical Nurse #13 at 8:00 PM they had to go home and that somebody from the facility would be calling them. They did not know why they were being sent home. During an interview on [DATE] at 11:15 AM, the Director of Nursing stated they received a text message from Registered Nurse Supervisor #12 before they left their shift on [DATE], acknowledging that Certified Nurse Aide #9 had come to them about how Certified Nurse Aide #7 sprayed perfume on Resident #1. Registered Nurse Supervisor #12 did not say Certified Nurse Aide #7 sprayed the perfume in the resident's face. The text message also documented that Certified Nurse Aide #8 wanted to speak with them about the perfume sprayed on Resident #1. Registered Nurse Supervisor #12 told them they looked at Resident #1 and they seemed fine. Ther was no documentation that Registered Nurse Supervisor #12 assessed Resident #1. When they interviewed Certified Nurse Aide #9 about the incident, they told them they did not see Certified Nurse Aide #7 spray the perfume into Resident #1's</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>face. Registered Nurse Supervisor #12 did not say anything about physical or verbal abuse by Certified Nurse Aide #7 toward Resident #1. During a phone interview on [DATE] at 12:27 PM, Registered Nurse Supervisor #12 stated they worked on [DATE] from 3:00 PM - 7:00 PM on both floors of the nursing home. They usually worked on the hospital side of the facility. Just before supper that evening, Certified Nurse Aide #9 told them Certified Nurse Aide #7 sprayed perfume on Resident #1 and the resident slapped them away. They thought maybe Resident #1 did not want to wear perfume. That was the only thing Certified Nurse Aide #9 told them. They did not think any kind of abuse occurred. They were aware Certified Nurse Aide #8 wanted to speak with them that shift but they got busy and never spoke with them. No other staff member sought them out. They worked until 7:00 PM. If they had known it was suspected abuse they would have called the Director of Nursing. They did transport Resident #1 in their wheelchair to the dining room that evening around 4:45 PM and the resident appeared fine and was smiling, but they were not sure if they documented that assessment in the nursing progress notes. They were always told not to document something if they were not sure of something. They spoke with the Director of Nursing after the fact but made no formal statement. During an interview on [DATE] at 1:30 PM, the Administrator stated the physical abuse occurred when Certified Nurse Aide #7 sprayed perfume in Resident #1's face. The verbal abuse was when Certified Nurse Aide #7 stated to Certified Nurse Aide #9, in front of Resident #1, they hoped Resident #5 died on the commode. During a phone interview on [DATE] at 2:21 PM, Certified Nurse Aide #9 stated on [DATE] between 4:00 PM - 4:30 PM they told Certified Nurse Aides #7 and #8 they had a few minutes to assist them with Resident #1 as their resident (later identified as Resident #5) was on the commode. Certified Nurse Aide #7 stated, in front of Resident #1, maybe they would get lucky, and Resident #5 would die on the commode. Resident #1 was being combative with care for Certified Nurse Aide #7, and once the resident was placed into their wheelchair, Certified Nurse Aide #7 grabbed Resident #7's (Resident #1's roommate) perfume and sprayed it on Resident #1's clothes. They told Registered Nurse Supervisor #12 about the comment Certified Nurse Aide #7 had stated in front of Resident #1 and how they sprayed perfume on the resident when they were being combative. They also told Registered Nurse #12 that Certified Nurse Aide #8 also wanted to speak with them about the incident. Registered Nurse Supervisor #12 told them they were done with their shift at 7:00 PM. Before Registered Nurse Supervisor #12 left for the evening they saw them at the nurse's station. They did not know if Registered Nurse Supervisor #12 had spoken with Certified Nurse Aide #8. The Director of Nursing called them at home later that evening and asked them what had happened. They gave a handwritten statement about the incident. During an interview on [DATE] at 2:53 PM, Licensed Practical Nurse #13 stated on [DATE] at approximately 7:30 PM Certified Nurse Aide #8 was upset and wanted to tell them about an incident involving Resident #1 and Certified Nurse Aide #7. They told them Registered Nurse Supervisor #12 was supposed to speak with them about the incident but had left at the end of their shift. They told them they saw Certified Nurse Aide #7 spray perfume at Resident #1's face, then changed the story to they had heard them spray perfume at Resident #1 but did not actually see them (Certified Nurse Aide #7) do it. They told Certified Nurse Aide #8 it sounded like abuse, and they needed to call the Director of Nursing. After speaking with the Director of Nursing, they were directed to send Certified Nurse Aide #7 home, which was around 8:00 PM. After Registered Nurse Supervisor #12 left at 7:00 PM, they did not have another nursing supervisor on the nursing home side of the building. If they needed a supervisor, they had to call the hospital side of the building. They had not heard anything on the evening of [DATE] regarding an abuse incident with Resident #2. 2) Resident #2 had diagnoses including osteoarthritis, knee replacement, and Alzheimer's disease. The [DATE] Minimum Data Set documented the resident had</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>severely impaired cognition, used a wheelchair, had lower extremity impairment on one side, was dependent to roll left and right and sit to stand, and did not ambulate. The Facility Accident/Incident Report completed by the Director of Nursing on [DATE], documented on [DATE]:-Resident #2's roommate (later identified as Resident #8, no longer at the facility) stated to staff (later identified as Licensed Practical Nurse #11), that Certified Nurse Aide #7 was rude to Resident #2, telling them they were not going to be doing that up and down thing all night.-The Director of Nursing was notified (by phone) of the incident by Licensed Practical Nurse #13 at 7:49 PM. Certified Nurse Aide #7 was suspended from work (later identified as approximately 8:00 PM). During an interview on [DATE] at 2:53 PM, Licensed Practical Nurse #13 stated they had only been made aware of the incident on [DATE] with Resident #1, and had not heard anything that evening about Resident #2.-A registered nurse assessment by the Director of Nursing was completed on Resident #2 on [DATE] (no time documented).-Nurse Practitioner #16 was notified of the incident by the Director of Nursing on [DATE] at 10:00 AM.-Resident #2's family representative was notified of the incident by the Administrator on [DATE] at 6:00 PM. During a phone interview on [DATE] at 10:37 AM, Certified Nurse Aide #7 stated on [DATE] during the evening shift, they had resident care assignments on both halls of Stillwater Unit. Resident #2 was ringing their call bell numerous times, and they told them they had other residents to care for and they could not keep coming into their room every few minutes to get them in and out of bed. They were told by Licensed Practical Nurse #13 at approximately 8:00 PM they had to go home and that somebody from the facility would be calling them. They were called by the facility on [DATE] to come into the facility on [DATE] for a meeting with Human Resources. They were told they were terminated from employment due to physical and verbal abuse toward Residents #1 and #2. During a phone interview on [DATE] at 11:00 AM, Certified Nurse Aide #10 stated Certified Nurse Aide #7 was assigned to Resident #2 and they were asked to help with putting Resident #2 to bed after supper. During the transfer into bed, Certified Nurse Aide #7 was rough when they put their arm under the resident's arm and when they lifted their legs into bed. Resident #2 stated it hurt and was crying. Certified Nurse Aide #7 stated to the resident they were done with the up and down game and to not get out of the bed. They (Certified Nurse Aide #10) asked Certified Nurse Aide #7 to leave the room. Before Certified Nurse Aide #7 left the resident's room, they went around to the side of the bed, leaned down towards the resident, and stated to them, They had been nothing but nice to them, and they were tired of the up and down game. They asked Certified Nurse Aide #7 to leave the room again, then they reported the incident to Licensed Practical Nurse #11 because they thought it was verbal abuse. Licensed Practical Nurse #11 went into Resident #2's room to speak with them. Resident #2 was upset for the rest of the shift. They did not see a registered nurse assess Resident #2. The registered nurse would have been Registered Nurse Supervisor #12. During an interview on [DATE] at 2:53 PM, Licensed Practical Nurse #13 stated on [DATE] during the evening shift, they were not aware of any incident of abuse towards Resident #2 by Certified Nurse Aide #7. The only incident they were made aware of was with Resident #1, which they reported to the Director of Nursing on [DATE] at 7:49 PM. During a phone interview on [DATE] at 5:35 PM, Licensed Practical Nurse #11 stated they were told by Certified Nurse Aide #10 on [DATE] after 7:00 PM about a verbal incident between Resident #2 and Certified Nurse Aide #7. Certified Nurse Aide #10 told them Certified Nurse Aide #7 was rude and curt with Resident #2 and seemed frustrated the resident kept wanting to get in and out of bed. They asked Resident #2's roommate (Resident #8, no longer at facility) about the verbal incident and it matched what Certified Nurse Aide #10 told them. Certified Nurse Aide #7 was not physically rough with Resident #2, they were just shaming and scolding them. When the incident was reported to them by Certified Nurse Aide #10,</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Certified Nurse Aide #7 had already been sent home (sent home at 8:00 PM). They did not feel it was verbal abuse, so they did not think it needed to be reported to a supervisor. Registered Nurse Supervisor #12 left at 7:00 PM so there was no supervisor to give a statement to. There was no registered nurse assessment of Resident #2 that evening. If Certified Nurse Aide #7 was physically inappropriate or demeaning to Resident #2, they would have reported it to the Director of Nursing. The Facility Investigation Summary for the [DATE] incidents involving Residents #1 and #2, completed by the Administrator on [DATE], documented:-On [DATE] in the early evening hours, Certified Nurse Aide #7 verbally and physically abused Residents #1 and #2. There was no serious bodily injury to either resident, but both may have suffered psychological harm.-Certified Nurse Aide #7 treated and turned Resident #1 very roughly and sprayed cologne over the resident's head and into their eyes as they were trying to hit and push Certified Nurse Aide #7 away. Certified Nurse Aide #9 came into the room and offered to assist (as their resident was on the commode). Certified Nurse Aide #7 then stated in front of Resident #1, Maybe they will get lucky and (the other resident) will die on the commode.-Certified Nurse Aide #7 was verbally rude to Resident #2, telling them they, Were not going to do this up/down, up/down thing all night! Resident #2 replied they were just trying to get comfortable. The conversation was overheard by Resident #2's roommate.-Certified Nurse Aide #7 was asked to leave the building.-At the close of the investigation it was determined that both physical and verbal abuse had occurred.-Certified Nurse Aide #7 was terminated from employment. During an interview on [DATE] at 4:10 PM the Administrator stated Residents #1 and #2 did not receive registered nurse assessments immediately after their incidents of verbal and physical abuse by Certified Nurse Aide #7 on [DATE]. They also stated the other residents on Stillwater Unit were not assessed by a registered nurse on [DATE] to see if any further abuse by Certified Nurse Aide #7 occurred. They stated they were Registered Nurse Supervisor #12's supervisor. Registered Nurse Supervisor #12 usually worked on the hospital side of the facility, and they did not know for certain if Registered Nurse Supervisor #12 had training as a supervisor for the nursing home side of the facility or if they knew what the expectation was if resident abuse was alleged. 10 New York Codes, Rules and Regulations 415.4(b)(3) Immediate Jeopardy was issued on [DATE] at 3:15 PM. The facility was notified Immediate Jeopardy was lifted as of [DATE] at 3:50 PM based on the following corrective actions:- All staff currently working in the facility (including staff who are employed by the hospital and work on the nursing home side) have been educated on Abuse, Identification of Abuse, and Reporting of Abuse.- 91% of all staff received education as of [DATE], with a plan to provide education to any staff on leave, prior to the start of their shift. - Confirmation of education via staff interviews on [DATE] including nursing staff, activity staff, social work, management, and environmen</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interviews during a survey, the facility failed to timely report witnessed verbal and physical abuse for two (2) of four (4) residents (Residents #1 and #2) reviewed, resulting in the alleged perpetrator having continued access to residents. Specifically, on 02/01/2026 at approximately 4:00 PM, Certified Nurse Aide #9 witnessed Certified Nurse Aide #7 handling Resident #1 roughly, spraying them with perfume when they were combative with care, and making a verbally abusive statement. Certified Nurse Aide #9 reported the incident to Registered Nurse Supervisor #12, who did not assess Resident #1. Certified Nurse Aide #7 continued to have access to residents, and after supper, they made a verbally abusive statement to Resident #2, which was witnessed by Certified Nurse Aide #10. Certified Nurse Aide #7 continued to have access to residents until they were suspended from duty on 01/01/2026 at 8:00 PM. Certified Nurse Aide #7 was sent home on suspension at 8:00 PM. The facility's failure to report abuse timely resulted in potential for harm that is Immediate Jeopardy and Substandard Quality of Care and places all 74 residents in the facility at risk for the likelihood of serious injury, serious harm, serious impairment, or death. Refer to F 600 Findings include: The facility policy Abuse Policy - Prevention and Reporting, revised 06/2025, documented when a facility had identified abuse, they must take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The facility would begin the investigation process immediately upon notification of the incident and would prevent further potential abuse while the investigation was in process. Steps involved in reporting abuse included the shift supervisor/charge nurse was identified as responsible for immediate initiation of the reporting process. 1) Resident #1 had diagnoses including aphasia (difficulty speaking), hemiplegia (one-sided paralysis), and anxiety disorder. The 11/09/2025 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, used a wheelchair, had impairment on one side of their lower and upper extremities and required substantial to maximal assistance for most activities of daily living. The Facility Accident/Incident Report completed by the Director of Nursing on 02/02/2026 for the incident that occurred on 02/01/2026 at 4:00 PM documented: -Licensed Practical Nurse #13 was taking their lunch break (time later identified as approximately 7:30 PM) when Certified Nurse Aide #8 told them Certified Nurse Aide #7 had sprayed perfume in Resident #1's face (witnessed occurrence was 4:00 PM). -The Director of Nursing was notified (by phone) of the incident by Licensed Practical Nurse #13 at 7:49 PM. Certified Nurse Aide #7 was suspended from work (time later identified as approximately 8:00 PM). There was no documented evidence the 4:00 PM witnessed incident was reported immediately to the Nursing Supervisor or Administrator. During an interview on 02/09/2026 at 12:10 PM, the Administrator stated the incident that occurred with Resident #1 on 02/01/2026 at 4:00 PM was not reported to the Director of Nursing until 8:00 PM. They knew they had two (2) hours to report physical abuse and up to 24 hours for all other abuse. During a phone interview on 02/09/2026 at 1:28 PM, Certified Nurse Aide #8 stated on 02/01/2026 at around 4:00 PM, they and Certified Nurse Aide #7 were getting Resident #1 cleaned up before supper. Resident #1 was combative with care. They thought they saw Certified Nurse Aide #7 spray Resident #1 with perfume from their peripheral vision, and they could smell perfume. Certified Nurse Aide #9 came into the room to see if assistance was needed and they saw Certified Nurse Aide #7 spray Resident #1 with perfume. They told Certified Nurse Aide #9 they needed to report the incident to Registered Nurse Supervisor #12. Certified Nurse Aide #9 left the room at around 4:20 PM to report the incident to Registered Nurse Supervisor #12. Certified Nurse Aide #9 returned to the unit and told them Registered Nurse Supervisor #12 would speak to them after supper about the incident. They reminded Registered Nurse Supervisor #12 again</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>that they needed to speak with them and they told them they would do so before 7:00 PM (when Registered Nurse Supervisor #12's shift ended). Registered Nurse Supervisor #12 left their shift before they spoke with them about the incident. Certified Nurse Aide #7 was still working, and they did not know why. They told Licensed Practical Nurse #13 about the incident at around 7:30 PM. Licensed Practical Nurse #13 stated they thought it sounded like abuse. Licensed Practical Nurse #13 called the Director of Nursing and was given instructions to send Certified Nurse Aide #7 home. During a follow-up interview on 02/09/2026 at 4:10 PM, the Administrator stated Registered Nurse Supervisor #12 should have started the Facility Accident/Incident Report form for the incident that had occurred on 02/01/2026 at 4:00 PM. They did not know if Registered Nurse Supervisor #12 had training as a supervisor on the nursing home side of the building (the facility was part of the hospital) or if Registered Nurse Supervisor #12 knew what was expected of them if abuse was alleged (Registered Nurse Supervisor #12 usually worked on the hospital side of the facility). All staff received annual abuse training. During an interview on 02/10/2026 at 11:15 AM, the Director of Nursing stated on 02/01/2026 Registered Nurse Supervisor #12 texted them before they left their shift (Registered Nurse Supervisor #12's shift ended at 7:00 PM) to update them on their shift. They told them Certified Nurse Aide #9 came to them about perfume sprayed on Resident #1 by Certified Nurse Aide #7, and how Certified Nurse Aide #8 also wanted to speak with them about it. Registered Nurse Supervisor #12 did not say if the perfume was sprayed into Resident #1's face. Registered Nurse Supervisor #12 also told them they looked at Resident #1 and they seemed fine. The Director of Nursing stated Certified Nurse Aide #9 told them they did not see Certified Nurse Aide #7 spray the perfume into Resident #1's face. They did not think there had been any abuse at that time. During a phone interview on 02/10/2026 at 12:27 PM with Registered Nurse Supervisor #12, they stated they worked on 02/01/2026 from 3:00 PM - 7:00 PM on both floors of the nursing home that evening. They usually worked on the hospital side of the facility. Certified Nurse Aide #9 had come to them before supper (before 5:00 PM) to inform them Certified Nurse Aide #7 sprayed perfume on Resident #1 and the resident slapped them away. They were not told about any other abuse issues with Resident #1. They did not think any type of abuse had occurred. They were aware Certified Nurse Aide #8 wanted to speak with them about the incident, but they got busy and left their shift (at 7:00 PM) before speaking with Certified Nurse Aide #8. They had annual abuse training and knew when to call immediately if abuse was suspected. During a phone interview on 02/10/2026 at 2:21, PM Certified Nurse Aide #9 stated they went into Resident #1's room on 02/01/2026 at around 4:00 PM to assist Certified Nurse Aides #7 and #8, as their resident (Resident #5) was on the commode. Certified Nurse Aide #7 then stated, in front of Resident #1, Maybe they will get lucky, and Resident #5 would die on the commode. Once Resident #1, who was being combative with care, was placed in their wheelchair, Certified Nurse Aide #7 sprayed perfume several times onto Resident #1's clothes. They reported the incident to Registered Nurse Supervisor #12 and told them Certified Nurse Aide #8 wanted to speak with them about the incident as well. Registered Nurse Supervisor #12 left their shift around 7:00 PM and never spoke with Certified Nurse Aide #8. During an interview on 02/10/2026 at 2:53 PM, Licensed Practical Nurse #13 stated Certified Nurse Aide #8 came to them on 02/01/2026 at around 7:30 PM to inform them Certified Nurse Aide #7 sprayed perfume at Resident #1 when they were being combative with care around 4:00 PM. They thought it was abuse, so they called the Director of Nursing. Certified Nurse Aide #7 was sent home on suspension at 8:00 PM. 2) Resident #2 had diagnoses including osteoarthritis (breakdown of cartilage in the joints) and Alzheimer's disease (a progressive brain disorder that leads to memory loss and cognitive decline). The 01/22/2026 Minimum Data Set documented the resident had severely impaired cognition, used a wheelchair, had lower</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335785	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2026
NAME OF PROVIDER OR SUPPLIER  Finger Lakes Center for Living		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>extremity impairment on one side, was dependent to roll left and right and sit to stand, and did not ambulate. The Facility Accident/Incident Report for Resident #2 completed by the Director of Nursing on 02/02/2026 documented on 02/01/2026 at supper time: -Resident #2's roommate (later identified as Resident #8, no longer at the facility) stated to staff (later identified as Licensed Practical Nurse #11), that Certified Nurse Aide #7 had been rude to Resident #2, telling them they were not going to be doing that up and down thing all night. -The Director of Nursing was notified (by phone) of the incident at 7:49 PM by Licensed Practical Nurse #13. Certified Nurse Aide #7 was suspended from work (later identified as approximately 8:00 PM. There was no documented evidence the incident was reported immediately to a nursing supervisor or the Administrator on 02/01/2026. The New York State hotline intake for the incident documented the Administrator was made aware of the incident with Resident #2 on 02/01/2026 at 8:18 PM. During an interview on 02/09/2026 at 12:10 PM the Administrator stated the incident that occurred with Resident #2 on 02/01/2026 after supper was not reported to the Director of Nursing until 8:00 PM. During an interview on 02/10/2026 at 2:53 PM, Licensed Practical Nurse #13 stated they only reported the incident with Resident #1 to the Director of Nursing on 02/01/2026 at 7:49 PM. At that time, they were not aware of the incident with Resident #2 on 02/01/2026 after supper. During a phone interview on 02/10/2026 at 5:35 PM, Licensed Practical Nurse #11 stated they were told by Certified Nurse Aide #10 on 02/01/2026 after supper that Certified Nurse Aide #7 was rude, curt, shaming, and scolding Resident #2 because they wanted to keep getting out of bed after being put into bed multiple times. They did not think the incident needed to be reported to a nursing supervisor because Certified Nurse Aide #7 had only been verbally inappropriate like a lot of the certified nurse aides were. If Certified Nurse Aide #7 was physically inappropriate or demeaning, they would have reported it to a nursing supervisor. Registered Nurse Supervisor #12 left their shift at 7:00 PM that evening so they did not have a nursing supervisor to report to. During a phone interview on 02/10/2026 at 11:00 AM, Certified Nurse Aide #10 stated when they were helping with Resident #2's care on 02/01/2026 after supper Certified Nurse Aide #7 was rough with the resident when they were putting them into bed and then told the resident, they were not going to play the up and down game all night. Certified Nurse Aide #10 stated they reported the incident to Licensed Practical Nurse #11 because they thought it was abuse. They were unaware if the incident had been reported to Registered Nurse Supervisor #12. 10 New York Codes, Rules and Regulations 415.4(b)(2) Immediate Jeopardy was issued on 02/13/2026 at 3:15 PM. The facility was notified Immediate Jeopardy was lifted as of 02/17/2026 at 3:50 PM based on the following corrective actions:- All staff currently working in the facility (including staff who are employed by the hospital and work on the nursing home side) have been educated on Abuse, Identification of Abuse, and Reporting of Abuse.- 91% of all staff received education as of 02/17/2025, with a plan to provide education to any staff on leave, prior to the start of their shift. - Confirmation of education via staff interviews on 02/17/2026 including nursing staff, activity staff, social work, management, and environmental services.</p>		