STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335786	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Living Center	500 Hahnemann Trail Pittsford, NY 14534

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The findings include:The facility policy Abuse, Neglect, and Mistreatment Prohibition, Investigation and Reporting, last reviewed April 2025, included the facility shall investigate and report any injury of unknown source immediately or within two (2) hours to the Department of Health.Resident #2 had diagnoses including dementia, pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged or scarred), and anxiety. The Minimum Data Set (resident assessment tool) dated 09/24/2025 revealed Resident #2 had moderate cognitive impairment and had one (1) fall with major injury (such as bone fractures) since the prior assessment. Review of Resident #2's Comprehensive Care Plan and Kardex (care plan used by certified nursing assistants to direct care), last revised 07/28/2025, revealed Resident #2 was independent with a four (4) wheeled walker for ambulation (walking).Review of a facility Incident Report dated 09/18/2025 revealed Resident #2 was pushed to the floor by another resident while walking in the hallway. Resident #2 landed on the right side and complained of pain to the right shoulder and elbow. The resident was found to have a right humeral fracture (arm fracture) and was transferred to the hospital. The report did not identify a right hip injury.Review of a New York State Department of Health Incident Intake dated 09/18/2025 revealed the facility reported a resident-to-resident altercation and a right humeral fracture requiring hospital evaluation.Review of a Hospital Discharge summary dated [DATE] revealed Resident #2 was treated for a right humeral fracture and discharged back to the facility.Review of a therapy progress note dated 09/23/2025 revealed Resident #2 resisted range of motion to the right lower extremity and grimaced with right hip flexion (bringing the thigh closer to torso/abdomen).Review of a provider visit note dated 09/24/2025 and documented by Physician Assistant #1 revealed worsening right hip pain. An x-ray identified an acute right femoral neck fracture (hip fracture). Resident #2 was transferred to the hospital for further evaluation and treatment.Review of a hospital Orthopedic (medical specialty focused on the conditions of the musculoskeletal system, such as bones) Surgery Consult dated 09/24/2025 revealed Resident #2 presented with right hip pain after being pushed by another resident on 09/18/2025. The consult documented difficulty bearing weight (the amount of body weight you a person can safely put on an injured limb) since the incident and identified a right femoral neck fracture.Review of a Hospitalization Summary dated 10/01/2025 revealed Resident #2 underwent a right hip hemiarthroplasty (partial hip replacement) on 09/25/2025 following identification of the right femoral neck fracture.Review of an Investigative Report submitted to the New York State Department of Health on 09/23/2025 and revised on 09/24/2025 revealed the report included the resident-to-resident altercation and right humeral fracture. The report did not include the right femoral neck fracture, hospitalization, or surgical intervention.During an interview on 05/27/2026 at 11:06 AM with Registered Nurse Manager #1 and Director of Nursing #1, Registered Nurse Manager #1 stated the facility assumed the hip fracture was related to the 09/18/2025 altercation. Registered Nurse Manager #1 stated no additional incident report was completed after the fracture was identified. Director of Nursing #1 stated the right hip fracture should have been reported to the State Survey Agency.Title 10 New York Codes, Rules and Regulations 415.4(b)(4)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335786	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands Living Center	500 Hahnemann Trail Pittsford, NY 14534

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure an alleged violation involving a resident-to-resident altercation resulting in a serious injury was thoroughly investigated for one (1) of seven (7) residents reviewed (Resident #2). Specifically, Resident #2 sustained a right femoral neck fracture (hip fracture) requiring hospitalization and surgical intervention following a resident-to-resident altercation, and the facility failed to conduct a thorough investigation after the fracture was identified.The findings include:The facility policy Abuse, Neglect, and Mistreatment, Prohibition, Investigation and Reporting, last reviewed April 2025, included injury of unknown origin will be thoroughly investigated with a written report. The investigation will include interviews of involved individuals, interviews of witnesses when available, statements from staff, review of relevant records, findings, and corrective actions as indicated.Resident #2 had diagnoses including dementia, pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged or scarred), and anxiety. The Minimum Data Set (resident assessment tool) dated 09/24/2025 revealed Resident #2 had moderate cognitive impairment and had one (1) fall with major injury (such as bone fractures) since the prior assessment. Review of a facility Incident Report dated 09/18/2025 revealed Resident #2 was pushed to the floor by another resident while walking in the hallway. Resident #2 sustained a right humeral fracture (arm fracture) and was transferred to the hospital.Review of a Hospital Discharge summary dated [DATE] revealed Resident #2 returned to the facility following treatment of the right humeral fracture.Review of a therapy progress note dated 09/23/2025 revealed Resident #2 resisted range of motion to the right lower extremity and grimaced with right hip flexion (bringing the thigh closer to torso/abdomen).Review of a provider visit note dated 09/24/2025 and documented by Physician Assistant #1 revealed worsening right hip pain. An x-ray identified an acute right femoral neck fracture. Resident #2 was transferred to the hospital for further evaluation and treatment.Review of a Hospitalization Summary dated 10/01/2025 revealed Resident #2 underwent a right hip hemiarthroplasty on 09/25/2025 following identification of the right femoral neck fracture.Review of facility records revealed no incident report was completed after the right femoral neck fracture was identified on 09/24/2025.Review of facility records revealed no documented investigation was completed to determine the cause of the fracture, whether the fracture was related to the 09/18/2025 resident-to-resident altercation, whether signs or symptoms of injury were missed following the incident, or whether additional corrective actions were needed.During an interview on 05/27/2026 at 11:06 AM with Registered Nurse Manager #1 and Director of Nursing #1, Registered Nurse Manager #1 stated the facility assumed the fracture was related to the 09/18/2025 altercation and there was no incident report or investigation completed after the fracture was identified. Director of Nursing #1 stated there should have been an incident report and a thorough investigation completed regarding the right hip fracture, including statements from caregivers.During an interview on 05/27/2026 at 1:30 PM, the Administrator stated the facility had work to do regarding investigations.During an interview on 05/28/2026 at 9:41 AM, Physician Assistant #1 stated Resident #2 was assessed following the 09/18/2025 altercation and complained only of right arm pain.During an interview on 05/28/2026 at 9:41 AM, Registered Nurse Manager #1 stated Resident #2 was assessed following the altercation, completed range of motion without complaints of hip pain, and was able to stand without difficulty.Title 10 New York Codes, Rules and Regulations 415.4(b)(2)