STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335112	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brothers of Mercy Nursing & Rehabilitation Center	10570 Bergtold Road Clarence, NY 14031

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. Based on interview and record review conducted during the survey, the facility failed to ensure that all alleged violations involving abuse or mistreatment are reported immediately but not later than 2-hours after the allegation is made if the events that cause the allegation involve abuse, to the Administrator of the facility and to other officials (including to the State Survey Agency) for one (Resident #2) of three residents reviewed. Specifically, an allegation of staff to resident physical abuse or mistreatment was not reported to the New York State Department of Health within the required two-hour timeframe. The findings include: A policy titled Freedom from Abuse, Neglect and Exploitation, Incident Reporting dated 01/2026 documented the facility does not condone any form of resident/patient abuse, neglect, exploitation or mistreatment. The policy documented if there was reasonable cause that abuse, mistreatment, or neglect occurred the Assistant Director of Nursing, Director of Nursing and/or Administrator were to notify the State Health Department. All alleged violations involving abuse, neglect, exploitation or mistreatment were to be reported immediately to the Assistant Director of Nursing, Director of Nursing or the Administrator/Compliance Officer, but not later than two hours after the allegation was made. Resident #2 had diagnoses including hypertension (high blood pressure), fracture of left hip and atrial fibrillation (rapid irregular heartbeat). The Minimum Data Set (a resident assessment tool) dated 02/25/2026 documented Resident #2 was cognitively intact, was understood and understands.The Care Plan Report dated 02/25/2026 documented Resident #2 did not have impaired cognitive function, dementia or impaired thought process. The resident was independent with decision making.During an interview on 06/02/2026 at 2:48 PM, the Administrator stated there were no abuse allegations documented or no grievances on file for Resident #2.During a telephone interview on 06/04/2026 at 9:00 AM, Registered Nurse Unit Manager #1 stated there was an abuse allegation from Resident #2 and their family but could not recall the date. They received a voicemail from a family member stating an aide was rough with the resident and pushed them into their wheelchair. They stated they reported this to the Director of Nursing right away. Registered Nurse Unit Manager #1 stated when they and the Director of Nursing spoke with Resident #2, the resident stated the aide was rough with them and pushed them into the wheelchair when they were not ready to get out of bed. Registered Nurse Unit Manager #1 stated they spoke with the aide, and the aide denied the allegation stating they thought someone was falling outside the resident's room, so they put the resident in their chair and went to investigate the noise in the hallway. The aide stated they returned to the resident to finish their care. Registered Nurse Unit Manager #1 stated when they interviewed Resident #2 again the resident stated it was no big deal and you're making something out of nothing. The family also stated it was nothing. Registered Nurse Unit Manager #1 stated they did not document any information in the progress notes and usually do not document abuse allegations. Registered Nurse Unit Manager #1 stated they were unsure what happened after that or if an investigation was completed, the aide was moved to a different unit. They stated all abuse allegations should be reported immediately to the Director of Nursing or Administrator.During a telephone interview on 06/04/2026 at 11:58 AM, the Director of Nursing stated there was no abuse allegation, Family Member #2 called them on 03/19/2026 and stated a staff (continued on next page)

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(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	member was rough with Resident #2. The Director of Nursing stated they spoke with Resident #2, and the resident told them the staff rushed them and stated it was no big deal. The Director of Nursing stated Resident #2 was becoming annoyed that everyone was asking them the same questions. The Director of Nursing stated they interviewed Certified Nurse Aide #1 and Certified Nure Aide #1 told them they rushed the resident into the wheelchair because they heard a noise in the hallway and went to check to make sure no one was hurt. The Director of Nursing stated they were unable to provide resident or staff statements or an investigation but had some notes they can provide. The Director of Nursing stated they did not remember if they reported this to the Administrator.During a telephone interview on 06/04/2026 at 1:12 PM, Family Member #2 stated they received a phone call from Resident #2 who was upset and stated the aide pushed her in the wheelchair. Family Member #2 stated Resident #2 liked most of the staff at the facility except this one aide which wasn't the first time the resident stated the aide was rough with her. Family Member #2 stated they spoke to Administration and/or a nursing supervisor, possibly the Director of Nursing who said they would go and check on Resident #2 but never heard back from anyone. Family Member #2 stated they spoke with Resident #2 the next day and the resident was told the aide did not mean to do it because the aide thought someone was falling in the hallway. Family Member #2 stated Resident #2 was upset and fearful and could have told staff it was no big deal to prevent retaliation. During a telephone interview on 06/05/2026 at 8:55 AM, Certified Nurse Aide #1 stated they recalled this resident and the incident. Certified Nurse Aide #1 stated they were transferring the resident from bed, and the resident was taking a long time to transfer to the wheelchair. Certified Nurse Aide #1 stated they heard a big boom in the hallway, and they explained to the resident they had to go see what happened and put the resident in the chair. The Director of Nursing spoke to them that day and stated Resident #2 complained Certified Nurse Aide #1 was rough to the resident. Nothing else was further said about the incident after Director of Nursing spoke with them and they were not asked to write a statement.During a telephone interview on 06/05/2026 at 10:50 AM, the Administrator stated they were not with the facility at the time of the incident but discussed it with the Director of Nursing yesterday (06/04/2026) and was unsure of all the details. The Administrator stated they would expect an investigation to start immediately and report to the state agency if any abuse was suspected. 10 New York Codes, Rules, Regulations 415.4(b)(2)

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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 interview and record review conducted during a survey, the facility failed to ensure that all alleged violations of abuse or mistreatment were thoroughly investigated for two (Residents #1 and #2) of three residents reviewed. Specifically, there was lack of evidence that thorough investigations were completed into allegations of a missing personal item (Resident #1) and physical abuse/mistreatment by a staff member (Resident #2). The findings include:A policy titled Freedom from Abuse, Neglect and Exploitation, Incident Reporting dated 01/2026 documented the facility does not condone any form of resident/patient abuse, neglect, exploitation or mistreatment. The Administrator has appointed the Director of Nursing or designee to coordinate an investigation when alleged incidents of abuse, neglect, mistreatment or misappropriation is reported.A policy titled Reporting Loss of Property with a revision date of 9/10/1999 documented loss of property that is reported by resident, staff or visitors is documented and communicated to designated facility staff. Follow up and investigation are then initiated to ensure that all necessary actions are taken to attempt to locate the missing property.1.Resident #1 had diagnoses including ovarian cancer, anxiety and depression. The Minimum Data Set (a resident assessment tool) dated 01/01/2026 documented Resident #1 was moderately cognitively impaired, was usually understood and usually understands.The Care Plan Report dated 03/09/2026 documented Resident #1 did not have impaired cognitive function, dementia or impaired thought process,Review of the Personal Belongings Checklist dated 01/09/2026 for Resident #1 documented they had a cell phone with a charger.Review of an e-mail provided by the Chief Executive Officer on 06/02/2026, sent by Family Member #1 of Resident #1 to Social Worker #1 dated 01/25/2026 at 10:58 AM, documented the family member was assured Resident #1's cellphone would be replaced and wanted to know when that would be as the resident was in a room with no access to a phone or ability to put one in. It was frustrating not being able to reach the resident.Review of an e-mail provided by the Chief Executive Officer on 06/02/2026, sent by Social Worker #1 to the Chief Executive Officer dated 01/26/2026 at 2:03 PM, documented Resident #1's family asked about the phone that was stolen and when it would be replaced.Review of the Progress Notes dated 01/04/2026 through 02/04/2026 revealed there was no documented evidence regarding Resident #1's missing cell phone.During an interview on 06/02/2026 at 3:17 PM, the Administrator stated they were waiting to hear from the Chief Executive Officer to see if there was any information regarding the missing phone. They were not with the facility at the time the phone went missing but would expect there would be some type of documentation or grievance form completed.During an interview on 06/02/2026 at 4:15 PM with the Administrator present, the Chief Executive Officer stated they recalled the missing phone. The Chief Executive Officer stated they could not provide a grievance form or documented evidence of an investigation to include resident and staff statements. The Chief Executive Officer stated they had some corresponding e-mails regarding the missing phone. The Chief Executive Officer stated the facility offered the family a cell phone they had on site, but the family opted for a landline instead of the phone being replaced and the family would pay for the service. During a telephone interview on 06/03/2026 at 02:33 PM, the former Social Worker #1 stated they recalled the resident's cellphone went missing. They filled out a missing items form and sent it to all departments. The facility searched everywhere for the phone, but it was never found. They never told the family it would be replaced but the family did follow up on a few occasions with other staff members asking if the phone was found. Former Social Worker #1 stated it was hit or miss if the facility would replace missing items and it was on a case-by-case basis. They left the facility shortly after the phone went missing and were unsure of the outcome. They could not recall if the resident had access to a locked drawer in their room but did not think there was one. During a telephone interview on 06/04/2026 at 1:26 PM, Family Member #1 of Resident #1 stated they were never offered a cell phone to use that the facility had. Family Member #1 stated they were told they could (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	buy a landline phone and pay for the service. The cell phone went missing out of Resident #1's room when they were at the hairdresser. It was reported to the Former Administrator #1. Family Member #1 stated they were told the phone would not be replaced by the facility and should have been locked up in the resident's room. Family Member #1 stated there was no locked drawer in Resident #1's room. Family Member #1 stated they never heard anything about the phone again. During a telephone interview on 06/05/2026 at 10:56 AM, the Administrator stated there was no additional information to provide regarding Resident #1's missing phone.2. Resident #2 had diagnoses including hypertension (high blood pressure), fracture of left hip and atrial fibrillation (rapid irregular heartbeat). The Minimum Data Set, dated [DATE] documented Resident #2 was cognitively intact, was understood and understands.The Care Plan Report dated 02/25/2026 documented Resident #2 did not have impaired cognitive function, dementia or impaired thought process. The resident was independent with decision making.During an interview on 06/02/2026 at 2:48 PM, the Administrator stated there were no abuse allegations documented or no grievances on file for Resident #2. During a telephone interview on 06/04/2026 at 9:00 AM, Registered Nurse Unit Manager #1 stated there was an abuse allegation from Resident #2 and their family but could not recall the date. They received a voicemail from a family member stating an aide was rough with the resident and pushed them into their wheelchair. When Registered Nurse Unit Manager #1 and the Director of Nursing spoke with Resident #2, the resident stated the aide was rough with them and pushed them into the wheelchair when they were not ready to get out of bed. Registered Nurse Unit Manager #1 stated they spoke with the aide, and the aide denied the allegation stating they thought someone was falling outside the resident's room, so they put the resident in their chair and went to investigate the noise in the hallway. The aide stated they returned to the resident to finish their care. Registered Nurse Unit Manager #1 stated when they interviewed Resident #2 again the resident stated it was no big deal and you're making something out of nothing. The family also stated it was nothing. Registered Nurse Unit Manager #1 stated they did not document any information in the progress notes and usually do not document abuse allegations. Registered Nurse Unit Manager #1 stated they were unsure what happened after that or if an investigation was completed. During a telephone interview on 06/04/2026 at 11:58 AM, the Director of Nursing stated there was no abuse allegation, Family Member #2 called them on 03/19/2026 and stated a staff member was rough with Resident #2. The Director of Nursing stated they spoke with Resident #2, and the resident told them the staff rushed them and stated it was no big deal. The Director of Nursing stated Resident #2 was becoming annoyed that everyone was asking them the same questions. The Director of Nursing stated they interviewed Certified Nurse Aide #1 and Certified Nure Aide #1 told them they rushed the resident into the wheelchair because they heard a noise in the hallway and went to check to make sure no one was hurt. The Director of Nursing stated they were unable to provide resident or staff statements or an investigation but had some notes they can provide.During a telephone interview on 06/04/2026 at 1:12 PM, Family Member #2 stated they received a phone call from Resident #2 who was upset and stated the aide pushed them into their wheelchair. Family Member #2 stated Resident #2 liked most of the staff at the facility except this one aide which was not the first time the resident stated the aide was rough. Family Member #2 stated they spoke to Administration and/or a nursing supervisor, possibly the Director of Nursing who said they would go and check on Resident #2 but never heard back from anyone. Family Member #2 stated they spoke with Resident #2 the next day and the resident was told the aide did not mean to do it because the aide thought someone was falling in the hallway. Family Member #2 stated Resident #2 was upset and fearful and could have told staff it was no big deal to prevent retaliation.During a telephone interview on 06/05/2026 at 8:55 AM, Certified Nurse Aide #1 stated they recalled this resident and the incident. Certified Nurse Aide #1 stated they were transferring the resident from bed, and the resident was taking a long time to transfer to the wheelchair. Certified Nurse Aide #1 stated they heard a big boom in the hallway, and they explained to the resident they had to go see what happened and put the resident in the chair. The Director of Nursing spoke to them that day and stated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 complained Certified Nurse Aide #1 was rough to the resident. Nothing else was further said about the incident after Director of Nursing spoke with them and they were not asked to write a statement.During a telephone interview on 06/05/2026 at 10:50 AM, the Administrator stated they were not with the facility at the time of the incident but discussed it with the Director of Nursing yesterday (06/04/2026) and was unsure of all the details. The Administrator stated they would expect an investigation to start immediately if a resident claimed a staff member was rough and reported to the state agency if any abuse was suspected. 10 New York Codes, Rules, Regulations 415.4(b)(3)