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	01/16/2026

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

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on observation, interview, and record review during the Standard survey completed on 01/16/2026, the facility did not operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes. Specifically, the facility was not in compliance with Section 915 of the 2020 Fire Code of New York State, which requires carbon monoxide detection in buildings with fuel-burning appliances and on-going preventative maintenance of carbon monoxide detectors. This affected four (4) (first, second, third, and fourth floors) of four (4) resident use floors.The finding is:The undated Directive and Procedure titled Testing of Carbon Monoxide Detectors documented the detectors will be manually tested weekly as per manufacturers specifications and must be kept free of dust and debris. Observations during the building tour on 01/12/2026 from 8:15 AM until 4:00 PM revealed fuel-burning appliances were located on the first and fourth floors of the facility. Further observation revealed single-station battery-operated carbon monoxide detectors were located at several locations on the first and fourth floors of the facility, and they were mostly Brand A and Brand B. The User Guide for Brand A carbon monoxide detectors documented to keep your alarm in good working order, you must test the alarm once a week by pressing the test/ reset button and vacuum the alarm cover once per month to remove accumulated dust. The User Manual for Brand B combination smoke and carbon monoxide alarm documented to keep your smoke/ carbon monoxide alarm in good working order, verify the unit's alarm sound and indicators are working properly by testing the unit once a week. Remove the unit from the ceiling or wall and clean the alarm cover and vents with a soft brush attachment once a month to remove dust and dirt. Review of the log titled Weekly Carbon Monoxide Detector Audit revealed it included eight (8) units and entries were dated for the seven (7) weeks between 11/18/2025 and 01/06/2026. During an interview on 01/13/2026 at 2:42 PM, the Maintenance Director stated they personally performed weekly carbon monoxide detector checks since they started working at this facility in November 2025, but they could not locate any documentation of carbon monoxide detector checks prior to November 2025. During an interview on 01/13/2026 at 2:50 PM, Maintenance Technician #1 stated they had not personally performed any carbon monoxide detector checks. At this same time, Maintenance Technician #2 stated they had tested the carbon monoxide detectors located in the Maintenance Shop a few times in Fall 2025, but did not document it. During an interview on 01/16/2026 at 1:05 PM, the Administrator stated they expected the carbon monoxide detectors in the building to be tested per manufacturer's guidelines. 42 CFR 483.70(b)10NYCRR: 415.29(a)(2), 711.2(a)(1)2020 Fire Code of New York State, Section 915: 915.3.1, 915.6

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that each resident was treated with respect and dignity, cared for in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality for three (3) (Resident #1, #32 and #59) of five (5) residents reviewed for dignity. Specifically, residents were treated disrespectfully and without dignity when a staff member spoke in an unprofessional manner (#32 and #59) while their room. Additionally, Resident #1 did not receive timely assistance with toileting resulting in them having an incontinence episode that was upsetting to them. The findings are: The procedure titled Dignity effective 11/14 documented all residents are to be treated in a manner which enhances/maintains dignity and quality of life with respect to each resident's individuality.New York State Department of Health, Your Rights as a Nursing Home Resident in New York State dated 2022, documented residents have the right to: Be treated with consideration, dignity and respect in full recognition of self-worth; Be cared for in a manner that enhances quality of life, free from humiliation; and receive adequate and appropriate care. 1. Resident #32 had diagnoses that included congested heart failure (chronic condition where the heart cannot pump enough blood), anxiety disorder, and chronic obstructive pulmonary disease (chronic lung disease). The Minimum Data Set (a resident assessment tool) dated 11/04/2025 documented Resident #32 was cognitively intact, understands and was understood by others.The comprehensive care plan dated 11/18/2025 documented that Resident #32 was independent with decision making and had capacity for health care decisions. The Kardex Report (a guide used by staff to provide care) dated 01/12/2026 documented Resident #32 was alert and oriented x3 (person, place and time) and was able to make their needs known. Resident #59 had diagnoses that included parkinsonism (a movement disorder with tremors, stiffness and slow movement), depression, and anxiety. The Minimum Data Set, dated [DATE] documented Resident #59 was cognitively intact, understands and was understood by others. The comprehensive care plan dated 11/25/2025 documented Resident #59 did not have impaired cognitive function/dementia or impaired thought processes. They required modified independence in decision making and had capacity for health care decisions. The Kardex Report dated 01/12/2026 documented Resident #59 was alert and oriented x3 (person, time, and place) and was able to make their needs known. During a resident council meeting conducted on 01/13/2026 at 10:15 AM, Resident #32 reported to the state surveyor that on 01/12/2026 Certified Nurse Aide #2 had been assisting their roommate (Resident #59) when Certified Nurse Aide #1 and Certified Nurse Aide #3 entered their room and began a personal conversation. Resident #32 stated when they asked the staff to leave the room and continue their conversation outside, Certified Nurse Aide #1 responded we wipe your (use of vulgar slang) all day and take care of you and this is how you talk to us. Resident #32 stated this was their home and Certified Nurse Aide #1's comment was rude and unacceptable. The concern was reported to the Assistant Director of Nursing and Director of Nursing immediately by the state surveyor. Review of the Nursing Home Facility Incident Report completed by the Director of Nursing dated 01/15/2026 documented an allegation of verbal/mental abuse that involved Resident #32 and Resident #59. The incident was reported on 01/13/2026 to the Director of Nursing and had documented Resident #32 stated there were three (3) staff members in their room having a personal conversation, they had asked the staff to leave their room when Certified Nurse Aide #1 responded we wipe your (use of vulgar slang) all day and take care of you and this is how you talk to us. The Director of Nursing interviewed and obtained statements from Certified Nurse Aide #1, #2, and #3, Certified Nurse Aide #1 was suspended pending further investigation and terminated on 01/15/2026. Certified Nurse Aide #2 and #3 were provided education on the right to privacy and dignified care. They documented foul language was used during this incident and could have been disparaging to the residents. Review of (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker #1's statement in the facility investigation folder dated 01/13/2026 documented Resident #32 reported Certified Nurse Aide #2 was assisting their roommate (Resident #59) when Certified Nurse Aide #1 and Certified Nurse Aide #3 entered their room and were talking loudly, they asked staff to leave the room and Certified Nurse Aide #1 responded to them we wipe your (use of vulgar slang) all day and take care of you and that's how you talk to us. Review of Social Worker #1's statement in the facility investigation folder dated 01/13/2026 documented they met with Resident #59 who reported last evening Certified Nurse Aide #2 was in their room making their bed when Certified Nurse Aide #1 and Certified Nurse Aide #3 entered their room and were talking loudly about their plans outside work. The statement documented Resident #59 stated their roommate (Resident #32) had asked the staff to leave and Certified Nurse Aide #1 made a comment about we wipe your (use of vulgar slang) all day and take care of you. Social Worker #1's statement documented Resident #59 stated the staff conversation was loud and rude. A written statement in the facility investigation folder dated 01/13/2026 and signed by Certified Nurse Aide #1 documented they had entered Resident #32's room to speak to another staff member, Resident #32 made a comment to them, and they responded to the resident stating we are leaving in a second, you do not have to be rude. An undated written statement in the facility investigation folder signed by Certified Nurse Aide #3 documented after Resident #32 asked them to take their conversation outside, Certified Nurse Aide #1 stated you can say it nicer, but we will leave. Certified Nurse Aide #3 documented they could not recall if Certified Nurse Aide #1 used any profanity in the room, they stated the comment was inappropriate and should not have been said, they apologized to both residents and left the room. During an interview on 01/14/2026 at 10:37 AM, Resident #32 stated on 01/12/2026, Certified Nurse Aide #2 was assisting their roommate (Resident #59), the door was opened and Certified Nurse Aide #1 and Certified Nurse Aide #3 entered without knocking and began a personal conversation with Certified Nurse Aide #2. Resident #32 stated when they asked the staff to take their conversation outside, Certified Nurse Aide #1 stated you wipe their (use of vulgar slang) and that is the way they treat us. Resident #32 stated Certified Nurse Aide #1 was rude, lacked manners and their comment was undignified but also stated they did not feel it was verbally abusive. They stated this was their home and they should not be spoken to in that manor. During an interview on 01/15/2026 at 9:31 AM, Resident #59 stated on 01/12/2026 Certified Nurse Aide #2 was making their bed when Certified Nurse Aide #1 and Certified Nurse Aide #3 walked in. They stated the staff members started to have a conversation with themselves, and their roommate (Resident #32) asked them to go out in the hallway to talk. Resident #59 stated Certified Nurse Aide #1 responded, you wipe their (use of vulgar slang) all day and your talked to like this. Resident #59 stated they did not remember the entire conversation, but the comment was rude and uncalled for but did not feel as it was verbally abusive. Resident #59 stated Certified Nurse Aide #1 was not directly speaking to them or Resident #32 but responded loud enough for both of them to hear. During an interview on 01/15/2026 at 11:20 AM, Certified Nurse Aide #3 stated on 01/12/2026 they went into Resident #32's room with Certified Nurse Aide #1 to speak to Certified Nurse Aide #2. They stated when Resident #32 asked them to take their conversation outside Certified Nurse Aide #1 stated you could say that in a nicer way and then left the room. Certified Nurse Aide #3 stated the comment was inappropriate and should not have been made but did not recall Certified Nurse Aide #1 using any profanity in the resident's room. They stated it was disrespectful to have walked into a resident's room and have a personal conversation, it was their home and should have waited outside their room. During an interview on 01/15/2026 at 3:31 PM. Certified Nurse Aide #2 stated on 01/12/2025 they were assisting Resident #59 when Certified Nurse Aide #1 and Certified Nurse Aide #3 entered the room to speak with them. Certified Nurse Aide #2 stated Resident #32 asked them to take their conversation into the hallway and then heard Certified Nurse Aide #1 make a comment we take care of you, and they talk to us however they want. They stated they did not recall Certified Nurse Aide #1 using any foul language towards the residents, did not consider the comment to be verbal abuse but was not appropriate and could have made the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents feel uncomfortable. During an interview on 01/16/2026 at 10:42 AM, Certified Nurse Aide #1 stated they had entered Resident #32's room to speak to another staff member, the resident became upset and yelled at staff to leave. Certified Nurse Aide #1 stated they had said, we were leaving in a second you do not have to be rude. Certified Nurse Aide #1 denied using any profanity towards either resident, they stated their response was inappropriate and should not have made it but did not feel it was verbally abusive. During an interview on 01/16/2026 at 12:57 AM, the Director of Nursing stated they had investigated and interviewed all staff involved in the incident that was reported to them on 01/13/2026. They stated upon interview Certified Nurse Aide #1 denied using any profanity in the resident's room, and their statement documented they had said, do not be rude to us. The Director of Nursing stated using profanities at any time was not an acceptable way to speak to any resident and even a comment of do not be rude was not acceptable. During an interview on 01/16/2026 at 1:22 PM, the Administrator stated they expected staff to treat all residents with dignity and respect. They stated the comments made by Certified Nurse Aide #1 in the presence of Resident #32 and Resident #59 was undignified and not an acceptable way to speak to any resident. 2. Resident #1 had diagnoses that included congestive heart failure (heart cannot pump blood as well as it should), cerebral infarction (stroke), and type 2 diabetes mellitus. The Minimum Data Set, dated [DATE] documented Resident #1 was cognitively intact, understands and was understood by others. Resident #1 was dependent for toilet transfers, and toileting hygiene. The Care Plan Report dated 12/06/2026 documented Resident #1 had a self-care deficit related to impaired mobility and physical limitations. Interventions revised 01/09/2026 documented the resident required partial/moderate assist of one (1) staff member; go slow and remind them to push up from the wheelchair armrests. Additionally, the care plan initiated 11/21/2025 documented that Resident #1 was at high risk for falls related to deconditioning, and gait/balance problems. Interventions documented for the call light to be within reach and the resident needed prompt response to all requests for assistance. The Kardex Report dated 01/15/2026 documented Resident #1 toilet transfer was touching assist of one (1), brief use needed. Resident alert and oriented times three (3) and able to make needs known. During an interview on 01/13/2026 at 11:55 AM, Resident #1 stated their call light went unanswered over the weekend for almost an hour. After they waited almost an hour, they wheeled themselves to the nurses' station and reported to staff, sitting at the nurses' station, they needed to use the bathroom. Resident #1 stated nobody came and they had to transfer themselves onto the toilet, even though they knew they were not supposed to. They stated they notified Licensed Practical Nurse #2 in the morning the following day, who stated they reported it to a nurse supervisor. Review of call light system log Group Incident List date range 01/09/2026-01/11/2026, documented Resident #1's room call light on 01/10/2026 was on from 5:32 PM to 6:31 PM. During an interview on 01/14/2026 at 9:39 AM and 01/16/2026 at 8:42 AM, Resident #1 stated the delayed response time to their call light and being ignored at the nurses' station upset them. They stated it made them cry because they needed help, no one came, and they had an incontinent episode. They stated after they had already transferred themselves onto the toilet, an unknown staff member entered the bathroom and threw a pull up and gown on their wheelchair and left. During an interview on 01/16/2026 at 8:31 AM, Licensed Practical Nurse #2 stated Resident #1 was upset and cried when speaking to them while taking their vital signs first thing in the morning over the weekend. They stated that Resident #1 reported that the evening before they were made to wait over an hour for their call light to be answered, then they went in their wheelchair to the nurses' station, informed and asked staff if they could take them to the bathroom and nobody did. Licensed Practical Nurse #2 stated Resident #1 then reported to them that they had to put themselves on the toilet and did not fully make it in time on the toilet and soiled themselves. During a telephone interview on 01/16/2026 at 10:30 AM, Registered Nurse Supervisor #2 stated if resident needs were not being met in a timely manner it could be considered neglectful. During a telephone interview on 01/16/2026 at 10:23 AM, Licensed Practical Nurse #7, per diem Supervisor, stated remembered Licensed Practical Nurse #2 coming into the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Supervisors Office at shift change on Sunday, 01/11/2026 (night shift into day shift) telling them about something but could not remember what it was. Licensed Practical Nurse #7, per diem Supervisor stated there were several people in the Supervisors Office and what Licensed Practical Nurse #2 reported was lost in translation. They stated if Licensed Practical Nurse #2 reported a resident concern it should have been addressed. During a telephone interview on 01/16/2026 at 10:30 AM, Registered Nurse Supervisor #2 stated if an allegation of abuse/neglect were brought to their attention, they would interview the resident, look to see what parties were involved and go from there. They stated if resident needs were not being meet in a timely manner it could be neglectful. During a telephone interview on 01/16/2026 at 11:40 AM, Certified Nurse Aide #1 stated they worked evening shift, 2:30 PM-10:30 PM, full time on 4 (four) [NAME] and had worked Saturday evening shift on 01/10/2026. Certified Nurse Aide #1 stated Resident #1 had voiced concerns that staff were not attentive to their needs at times. They did not recall Resident #1 being upset that evening and was not aware there was a delay in their call light being answered. They stated if a resident voiced a complaint, they should report it to a nurse or supervisor. During a telephone interview on 01/16/2026 at 11:40 AM, Certified Nurse Aide #1 stated they worked evening shift, 2:30 PM-10:30 PM, full time on 4 (four) [NAME] and had worked Saturday evening shift on 01/10/2026. Certified Nurse Aide #1 stated Resident #1 had voiced concerns that staff were not attentive to their needs at times but did not elaborate; they had just listened and allowed the resident time to vent. They did not recall Resident #1 being upset that evening and was not aware there was a delay in their call light being answered. During an interview on 01/16/2026 at 11:00 AM, the Director of Nursing (covering Nurse Manager 4 West) stated unit managers, charge nurses were responsible for ensuring the resident's care plan/Kardex was followed. They stated if care was not completed per the care plan/Kardex a resident's dignity may be compromised. During an interview on 01/16/2026 at 12:32 PM, the Director of Nursing stated it was not reasonable for a resident to have to wait an hour to be toileted. They stated they would have expected nursing staff to assist Resident #1, if sitting at the nurses' station whether they were assigned to Resident #1 or not. The Director of Nursing stated the Nursing Supervisor should have acknowledged Licensed Practical Nurse #2, so a conversation with Resident #1 was completed. 10NYCRR 415.3

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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** Based on interview and record review the facility did not ensure that all alleged violations involving abuse were reported immediately but not later than two (2) hours after the allegation was made to the State Survey Agency for two (2) (Residents #32 & Resident #59) of five (5) residents reviewed for abuse. Specifically, an allegation of verbal abuse was not reported to the New York State Department of Health within the required (2) two-hour timeframe. The findings are: The procedure titled Freedom from Abuse, Neglect and Exploitation, Incident Reporting revised 12/2025 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, but not later than two (2) hours after the allegation was made. 1. Resident #32 had diagnoses that included congested heart failure (chronic condition where the heart cannot pump enough blood), anxiety disorder, and chronic obstructive pulmonary disease (chronic lung disease). The Minimum Data Set (a resident assessment tool) dated 11/04/2025 documented Resident #32 was cognitively intact, understands and was understood by others.The comprehensive care plan dated 11/18/2025 documented that Resident #32 was independent with decision making and had capacity for health care decisions. Resident #59 had diagnoses that included parkinsonism (a movement disorder with tremors, stiffness, and slow movement), depression, and anxiety. The Minimum Data Set, dated [DATE] documented Resident #59 was cognitively intact, understands, and was understood by others. The comprehensive care plan dated 11/25/2025 documented Resident #59 did not have impaired cognitive function/dementia or impaired thought processes. They required modified independence in decision making and had capacity for health care decisions. During a resident council meeting conducted on 01/13/2026 at 10:15 AM, Resident #32 reported to the state surveyor that on 01/12/2026 Certified Nurse Aide #2 had been assisting their roommate (Resident #59) when Certified Nurse Aide #1 and Certified Nurse Aide #3 entered their room and began a personal conversation. Resident #32 stated when they asked the staff to leave and continue their conversation outside, Certified Nurse Aide #1 responded we wipe your (vulgar slang) all day and take care of you and this is how you talk to us. Resident #32 stated this was their home and Certified Nurse Aide #1's comment was rude and unacceptable. The incident was reported to the Assistant Director of Nursing and Director of Nursing immediately by the State Surveyor. Review of the Nursing Home Facility Incident Report Submission completed by the Director of Nursing dated 01/15/2026 documented an allegation of verbal/mental abuse that involved Resident #32 and Resident #59. The report documented nursing staff were made aware of the allegation on 01/13/2026 at 10:00 AM, the Administrator was notified on 01/13/2026 at 1:00 PM and the allegation of verbal/mental abuse was reported to the Department of Health on 01/15/2026 at 12:16 PM. During an interview on 01/15/2026 at 10:16 AM, Social Worker #1 stated they were notified on 01/13/2026 by the Director of Nursing that Resident #32 reported a staff concern during the resident council meeting that took place that morning. Social Worker #1 stated they interviewed both Resident #32 and Resident #59 after being made aware of their concern with Certified Nurse Aide #1, they had documented both resident's statements and forwarded them to the Director of Nursing and Administrator on 01/13/2026. During an interview on 01/15/2026 at 3:28 PM, the Assistant Director of Nursing stated they were informed on 01/13/2026 by a state surveyor that Resident #32 had reported a concern during the resident council meeting that Certified Nurse Aide #1 had made an inappropriate comment to them 01/12/2026. The Assistant Director of Nursing stated the Director of Nursing had been made aware, Certified Nurse Aide #1 was suspended, and the Director of Nursing was responsible to conduct the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation. During a telephone interview on 01/16/2026 at 11:15 AM, Licensed Practical Nurse #9 stated on 01/12/2026 Resident #32 had complained to them about staff speaking loudly and having personal conversations in their room. Licensed Practical Nurse #9 stated Resident #32 reported when they asked the staff to leave their room, Certified Nurse Aide #1 mumbled something under their breath and walked out. They stated Resident #32 reported to them they did not understand what Certified Nurse Aide #1 had said to them and did not inform them that any profanity was used. Licensed Practical Nurse #9 stated they did not report Resident #32's concern to anyone because the resident could not say what Certified Nurse Aide #1 had said to them. They stated the use of profanity directed towards a resident could be considered verbally abusive and needed to be reported immediately.During an interview on 01/16/2026 at 12:57 AM, the Director of Nursing stated they had investigated and interviewed all staff involved in the incident that was reported to them on 01/13/2026. The Director of Nursing stated they did not report the allegation of verbal/mental abuse to the Department of Health until 01/15/2026 because they had initially considered the allegation to be more of a dignity concern. They stated after further investigation and review of the State Operation Manual they concluded verbal abuse had occurred and reported the allegation. The Director of Nursing stated all allegations of abuse were to be reported within two (2) hours of being notified. During an interview on 01/16/2026 at 1:22 PM, the Administrator stated they were made aware of Resident #32's allegation by the Director of Nursing on 01/13/2026. They stated the allegation was not reported to the Department of Health the same day because they were still conducting the investigation. The Administrator stated the investigation concluded verbal abuse occurred and the allegation was reported to the Department of Health on 01/15/2026. They stated technically any allegation of abuse was to be reported within two hours of notification and would consider this to be delayed reporting. 10 NYCRR 415.4 (b) (2)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the Standard survey completed on 01/16/2026, the facility did not ensure that residents who are unable to carry out activities of daily living receives the necessary services to maintain personal hygiene to meet the resident's needs for two (Resident #1 and #168 of two residents reviewed for toileting. Specifically, residents were not provided with toileting assist as planned. The findings are:The procedure titled Careplanning, Closet Careplans, Careguides- Nursing dated 06/19 documented comprehensive care plans were developed for each resident that includes measurable objectives and timetables to meet the resident's needs.The procedure titled Incontinent Care dated 1/2016 documented incontinent care was to be provided after each episode of incontinence by nurses and certified nursing assistants according to current standards of practice and the goal of this is to promote cleanliness, comfort, and personnel hygiene for the resident. Residents who were incontinent will be checked every two hours for incontinence unless care planned otherwise.1. Resident #1 had diagnoses that included congestive heart failure (heart cannot pump blood as well as it should), cerebral infarction (stroke), and type 2 diabetes mellitus. The Minimum Data Set (a resident assessment tool) dated 12/11/2025 documented Resident #1 was understood, understands and was cognitively intact. Resident #1 was dependent on staff for toilet transfer, and toileting hygiene.The Care Plan Report dated 12/06/2025 documented Resident #1 had a self-care deficit related to impaired mobility and physical limitations. Interventions revised 01/09/2026 documented the resident required partial/moderate assist of one (1) staff member; go slow and remind them to push up from the wheelchair armrests. Additionally, the care plan initiated 11/21/2025 documented that Resident #1 was at high risk for falls related to deconditioning, and gait/balance problems. Interventions documented for the call light to be within reach and the resident needed prompt response to all requests for assistance.The Kardex Report (guide used by staff to provide care) dated 01/15/2026 documented Resident #1 toilet transfer was touching assist of one (1), brief use needed. Resident alert and oriented times three (3) and able to make needs known.During an interview on 01/13/2026 at 11:55 AM, Resident #1 stated their call light went unanswered over the weekend for almost an hour. They stated after they waited almost an hour, they wheeled themselves to the nurses' station and reported to staff, sitting at the nurses' station, they needed to use the bathroom. Resident #1 stated nobody came and they had to transfer themselves onto the toilet, even though they knew they were not supposed to. They stated they notified Licensed Practical Nurse #2 in the morning the following day, who stated they reported it to a nurse supervisor.Review of call light system log Group Incident List date range 01/09/2026-01/11/2026, documented Resident #1's room call light on 01/10/2026 was on from 5:32 PM to 6:31 PM.During an interview on 01/14/2026 at 9:39 AM, Resident #1 stated the delayed response time to their call light and being ignored at the nurses' station upset them. They needed help, no one came, and they had an incontinent episode.During a follow up interview on 01/16/2026 at 8:42 AM, Resident #1 stated after they had already transferred themselves onto the toilet, an unknown staff member entered the bathroom and threw a pull up and gown on their wheelchair and left. They stated they did not report concern to the nurse working at the time because they were busy passing medications.During an interview on 01/16/2026 at 8:31 AM, Licensed Practical Nurse #2 stated Resident #1 was upset when speaking to them while taking their vital signs first thing in the morning over the weekend. They stated that Resident #1 reported that the evening before they were made to wait over an hour for their call light to be answered, then they went in their wheelchair to the nurses' station, informed and asked staff if they could take them to the bathroom and nobody did. Licensed Practical Nurse #2 stated Resident #1 then reported to them that they had to put themselves on the toilet and did not fully make it in time on the toilet and soiled themselves.During a telephone interview on 01/16/2026 at 10:30 AM, Registered Nurse Supervisor #2 stated if resident (continued on next page)

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	335112	A. Building B. Wing	01/16/2026

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needs were not being met in a timely manner it could be considered neglectful.During a telephone interview on 01/16/2026 at 11:40 AM, Certified Nurse Aide #1 stated they worked evening shift, 2:30 PM-10:30 PM, full time on 4 (four) [NAME] and had worked Saturday evening shift on 01/10/2026. Certified Nurse Aide #1 stated Resident #1 had voiced concerns that staff were not attentive to their needs at times. They did not recall Resident #1 being upset that evening and was not aware there was a delay in their call light being answered.During a telephone interview on 01/16/2026 at 12:01 PM, Certified Nurse Aide #11 stated their shift started at 6:30 PM on Saturday, 01/10/2026, and that Resident #1 told them they had not had a good day prior to them (Certified Nurse Aide #11) coming in.During an interview on 01/16/2026 at 12:32 PM, the Director of Nursing stated it was not reasonable for a resident to have to wait an hour to be toileted. They stated they would have expected nursing staff to assist Resident #1, if sitting at the nurses' station whether they were assigned to Resident #1 or not.2. Resident #168 had diagnoses that included fracture of right femur (a break of the thigh bone), dementia, major depressive disorder. The Minimum Data Set, dated [DATE] documented Resident #168 was severely cognitively impaired was rarely/never understood, and rarely/never understands others. Resident #168 was dependent for toileting hygiene and bowel incontinence was not rated.The Kardex Report dated 01/15/2026 documented Resident #168 required dependent assist with hygiene. Toileting: bedpan/incontinent care. Bladder/Bowel check every two hours and assist with toileting as needed.The Care Plan Report dated 12/23/2025 documented impaired cognitive function/dementia. Interventions documented for staff to anticipate residents needs as needed. The Care Plan Report dated 12/30/2025 documented Resident #168 had bowel incontinence. Interventions documented to check resident every two hours and assist with toileting as needed. The Care Plan Report dated 01/02/2026 documented Resident #168 had an activities of daily living deficit related physical impairments and interventions included to assist with hygiene and the resident was dependent on staff for the use of a bedpan and incontinent care.During a continuous observation on 01/15/2026 from 8:45 AM to 11:45 AM, Resident #168 was sitting in their wheelchair across from the nurse's station. At 11:45 PM the resident was transported from nurse's station by Certified Nurse Aide #8 into the dining room and served their lunch tray.During an observation and interview on 01/15/2026 at 12:11 PM, Resident #168 was in bed, fully dressed and Certified Nursing Aide #6 was covering resident with a sheet. Certified Nurse Aide #6 stated that Resident #168 was dependent on staff for their care, and they were assigned to them. They stated they try to check Resident #168 for incontinence every hour and do that by opening their incontinent brief. Certified Nurse Aide #6 stated they had not checked Resident #168 for incontinence since they arrived at 6:30 AM because it was hectic. They stated they try to follow the care plan and do the best they can. Certified Nurse Aide #6 stated they did not know if Resident #168 had any skin issues on their buttocks. Certified Nurse Aide #6 stated it was important to provide timely incontinent care because residents were human beings, to prevent urinary tract infections and skin breakdown. Additionally, Certified Nurse Aide #6 stated Resident #168 was already out of bed this morning when they arrived, and this would be the first time providing incontinent care on them that day.During a care observation on 01/15/2026 at 12:34 PM Resident #168 had been incontinent of stool, and at this time was provided with fecal incontinence care.During an interview on 01/16/2026 at 8:46 AM, Certified Nurse Aide #8 stated they had not assisted Certified Nurse Aide #7 and had not provided any care on Resident #168 until after lunch on 01/15/2026.During an interview on 01/16/2026 at 9:12 AM, Licensed Practical Nurse #1 stated Resident #168 was care planned to be checked every two hours and assisted with care as needed. They stated it was important for the care plan to be followed for hygiene purposes, infection control, and to prevent skin breakdown. They stated nurses were responsible to ensure that certified nurse aides were performing care per the resident's care plan.During an interview on 01/16/2026 at 11:00 AM, the Director of Nursing (covering Nurse Manager 4 West) stated unit managers and charge nurses were responsible for ensuring the resident's care plan/Kardex was followed. They stated if care was not completed per the care plan/Kardex a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's dignity may be compromised, infections and skin breakdown could occur.10NYCRR 415.12(a)(3)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that a resident who entered the facility with an indwelling (foley) catheter (tube inserted into the bladder to drain urine) was assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary for one (1) (Resident #168) of one (1) resident reviewed. Specifically, there was lack of a voiding trial (removal of a urinary catheter to see if someone can pass urine normally) when the resident was admitted to the facility from the hospital with a foley catheter. Additionally, there was lack of documented medical justification for the use of the foley catheter; and the catheter bag and tubing were observed on the floor on several occasions. The finding is:The policy titled Foley Catheter Care, effective 1/2026, documented to reduce the risk of catheter-associated urinary tract infections (CAUTIs) and other complications by ensuring proper technique, maintenance, and monitoring of indwelling urinary catheters. Indwelling catheters will be used only when clinically indicated, maintained using aseptic technique, and removed as soon as no longer medically necessary. Proper catheter care is essential to prevent infection, trauma, and resident harm. Licensed Nursing staff are responsible to advocate for timely catheter removal. Certified Nursing Assistants are responsible to ensure drainage bag positioning and tubing safety. Daily foley catheter care daily and after any episode of incontinence; ensure catheter is securely anchored, free from kinks or tension. Drainage bag care included do not allow bag to touch the floor.1. Resident #168 had diagnosis that included fracture of right femur (a break of the thigh bone), dementia, major depressive disorder. The Minimum Data Set (resident assessment tool) dated 12/28/2025 documented Resident #168 was rarely/never understood, rarely/never understands and was severely cognitively impaired. Resident #168 was dependent for toileting hygiene and had an indwelling catheter. The Visual/Bedside Kardex (overview of resident care) dated 01/15/2026 documented foley catheter care every shift per facility protocol and was dependent on staff for hygiene.The Care Plan Report dated 12/30/2025 documented Resident #168 had a foley catheter on admission, has urinary retention. Approaches included foley catheter care every shift per facility protocol, monitor for signs/symptoms of infection, output monitoring, position catheter bag and tubing below the level of the bladder at all times.Hospital Discharge summary dated [DATE] documented the foley catheter was to be removed once they were more ambulatory. There was no documented evidence of a diagnosis to clinically indicate/support the use of a foley catheter. Nursing admission Data Collection Form dated 12/22/2025, documented Resident #168's usual bladder pattern was incontinent with use of a pad/brief/liner. There was no history of urinary retention or urinary tract infections. An indwelling catheter was documented as present with no reason for its use. Order Review Report for 12/22/2025-01/15/2026, documented provide foley care every shift. There were no other orders for the size or maintenance of the foley catheter. Review of interdisciplinary Progress Notes from 12/22/2025 to 01/15/2026, revealed a social services note dated 01/07/2026 at 9:46 AM, documented Resident #168 was admitted from the hospital with diagnosis of acute urinary retention and the Director of Nursing planned to ask for a void trial. There was no documentation that a voiding trial was ordered or completed.Review of Medical Visits dated 12/23/2025, 12/24/2025, 01/06/2026, 01/08/2026, 01/13/2026 lacked documented evidence of the presence of an indwelling catheter and a valid clinical indication to support the use of an indwelling catheter. Intermittent resident observations revealed the following:-on 01/12/2026 at 9:39 AM, Resident #168 was lying in bed with the foley catheter drainage bag spigot and bottom of bag resting on the floor. No privacy bag was observed. -on 01/14/2026 at 4:38 PM, Resident #168 was lying in bed with a brief on, their lower extremities were uncovered, and foley catheter drainage bag secured to side of bed touching the floor. Strong urine odor was present. Urine in foley drainage bag was dark honey colored. The foley catheter (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appeared to be pulling and was not secured to Resident #168's leg. -on 01/14/2026 at 4:44 PM, Licensed Practical Nurse #3 observed Resident #168 and stated the foley drainage bag was touching the floor and should not be. They stated that foley drainage bags should be in a privacy bags, so they are out of sight and not touching the floor for infection control purposes. Licensed Practical Nurse #3 stated the foley catheter should be secured with a leg strap to Resident #168's leg to keep the foley catheter from tugging. They stated it was nursing staffs' responsibility to make sure that foley catheters were not kinked and were draining properly so urine was not stuck in the bladder causing problems. -on 01/15/2026 at 12:24 PM-12:58 PM, Resident #168 was lying in bed, Certified Nurse Aide #6 and Certified Nurse Aide #8 were preparing for incontinent care when it was noted that the foley catheter had disconnected from the foley draining bag after their pants were removed. The foley catheter was not secured to the resident and was taut/stretched. Certified Nurse Aide #8 retrieved a new foley drainage bag, handed it to Certified Nurse Aide #6 whom connected the foley catheter to the drainage bag then placed the drainage bag directly on the floor. Certified Nurse Aide #8 assisted with placing a leg strap to Resident #168's right thigh to secure their foley catheter. During an interview on 01/15/2026 at 12:37 PM, Certified Nurse Aide #8 stated they secured Resident #168's foley catheter to their thigh with a leg strap to help keep the foley catheter from pulling and to help placement. They stated without securing the foley catheter it could cause tension. During an interview on 01/15/2026 at 12:58 PM, Certified Nurse Aide #6 stated they did not know why a foley drainage bag should not be placed on the floor. They stated the facility did not teach them the things they are supposed to know.During an interview on 01/16/2026 at 8:53 AM and 11:00 AM, the Director of Nursing stated they were not sure why Resident #168 had a foley catheter. They stated there should be documentation from the medical providers as to why the foley catheter is warranted because they would not just want a foley catheter present without a reason as it was a source of infection. The Director of Nursing stated a foley catheter bag, tubing should never be on the floor due to infection control. The foley drainage bags should be placed in a dignity (privacy) bag. Additionally, they stated a voiding trial would be determined by the medical providers. During an interview on 01/16/2026 at 8:58 AM, the Assistant Director of Nursing/Infection Preventionist stated certified nurse aides and nurses were responsible to complete catheter care. The Assistant Director of Nursing/Infection Preventionist stated the foley drainage bag should be positioned below the level of the bladder and placed in a privacy bag. They stated the drainage bag, spout, and tubing should never be placed on the floor, it was an infection control issue and could lead to an infection. During an interview on 01/16/2026 at 9:12 AM, Licensed Practical Nurse #1 stated Resident #168 had a foley catheter since admission and did not know why. They stated they would have to look for the reason. They stated the medical providers determine when a foley catheter is removed and when to perform a voiding trail. During an interview and observation on 01/16/2026 at 11:10 AM, Nurse Practitioner #1 stated they try to have foley catheters removed as soon as possible. They stated they were aware that Resident #168 had a foley catheter and believed per the family Resident #168 had several failed voiding trials at the hospital. Nurse Practitioner #1 stated typically foley catheter use and reason for use were documented in the admission note by the medical provider. The Nurse Practitioner #1 reviewed their progress notes and stated the indication for use of a foley catheter was not addressed and it was an oversight. They stated it was important for the use of foley catheters to be documented on in their progress notes per regulation, resident plan of care, and foley management. They stated removal of foley catheters reduced the risk of catheter-associated urinary tract infections. 10NYCRR 415.12(d)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and a comfortable environment, to help prevent the development and transmission of communicable diseases and infections for two (2) (Residents #15 and #152) of six (6) residents reviewed. Specifically, Resident #15 had a pressure ulcer with drainage that required a dressing and was not placed on Enhanced Barrier Precautions (interventions designed to reduce the transmission of multi-drug resistant organisms, including gowns and glove use during high contact resident care activities); staff did not wear personal protective equipment (gowns) while providing incontinent care for Resident #152 who was on Enhanced Barrier Precautions for a chronic wound. The findings are:The Policy titled Surveillance, Prevention and Control of Infection and Enhanced Barrier Precautions revised 12/25/2024, documented residents/patients are placed on Enhanced Barrier Precautions in appropriate situations as defined/guided by Centers for Disease Control, Centers for Medicaid/Medicare Services, and New York State Department of Health. Appropriate situations include but are not limited to presence of a chronic open wound that is determined to not heal in 14 days such as: pressure ulcers, venous ulcers, arterial ulcers, diabetic ulcers, open lesions, dehisced or open surgical wounds. The purpose of Enhanced Barrier Precautions is to protect residents/patients that are susceptible to contacting and or spreading MDRO's (multi-drug-resistant organism). An Enhanced Barrier Precautions, orange sign will be obtained and placed on the resident/patient's door. Gloves and gowns are indicated when care/tasks are high contact.1.Resident #15 had diagnoses that included dementia, protein calorie malnutrition, and hypothyroidism (underactive thyroid gland). The Minimum Data Set (a resident assessment tool) dated 10/23/2025 documented Resident #15 was rarely understood, rarely understands and had severe cognitive impairment. Resident #15 was at risk for impaired skin integrity and there was no pressure ulcers documented.The comprehensive care plan revised on 01/07/2026, documented Resident #15 had an unstageable (full thickness wound where base is covered by dead tissue) pressure ulcer to their right and left trochanter. Interventions included to administer treatments as ordered and provide wound consults and follow up as needed. Further review of the care plan revealed Enhanced Barrier Precautions had not been implemented until 01/15/2026.Review of the Kardex (guide used by staff to provide care) Report dated 01/15/2026 revealed no documented evidence that Resident #15 required Enhanced Barrier Precautions.Review of the Order Review Report dated 10/17/2025 - 01/31/2026 which included all active, completed and discontinued orders revealed there was no order in place for Enhanced Barrier Precautions until 01/14/2026.Review of the Wound Assessment Report dated 01/06/2026, the Wound Consultant documented that Resident #15 had an unstageable pressure ulcer to their right and left trochanter (bony prominence at the top of the thigh bone) that was acquired on 01/02/2026. The wound status documented both unstageable pressure ulcers as being new with 100 percent eschar (black or brown dead tissue) to wound base, erythema (redness of skin) to peri wound, and light amount of serous drainage (clear/yellow drainage) was noted.Review of the Wound Assessment Report dated 01/13/2026, the Wound Consultant documented Resident #15's wound status as being stable with 100 percent eschar to wound base, erythema to peri wound and light amount of serous drainage was noted to both right and left unstageable pressure ulcers.During intermittent observations made on 01/12/2026 at 9:12 AM, 01/13/2026 at 11:05 AM, and 01/14/2026 at 10:11 AM, there was no Enhanced Barrier Precaution signage posted on Resident #15's door and no personal protective equipment was located outside or inside of Resident #15's room.During a wound care observation on 01/14/2026 at 3:25 PM, Licensed Practical Nurse #8 and Certified Nurse Aide #13 entered Resident #15's room, performed hand hygiene and applied gloves. There was no Enhanced Barrier Precaution sign on Resident #15's door and no gowns were present in the room. Licensed Practical Nurse #8 removed the old dressing from Resident #15's right hip and immediately placed it in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the garbage, the right hip unstageable pressure ulcer was observed with eschar present to the wound bed, wound edges were moist, and the peri wound was reddened. Licensed Practical Nurse #8 cleansed the wound with normal saline, applied Medi-honey (cream use to treat acute and chronic wounds including ulcers) and covered the wound with an adhesive foam dressing. Licensed Practical Nurse #8 repositioned Resident #15 and removed the old dressing from their left hip. The dressing removed from Resident #15's left hip was observed with a moderate amount of drainage that covered 75 percent of the dressing, the wound bed was covered with eschar and the wound edges were yellow and moist. During the wound care observation Licensed Practical Nurse #8 stated the drainage was a mixture of the old Medi -honey cream with yellow/green pus colored drainage present. Licensed Practical Nurse #8 cleansed the wound with normal saline and applied Medi-honey as ordered and covered the wound with an adhesive foam dressing. Licensed Practical Nurse #8 and Certified Nurse Aide #13 utilized gloves and masks for personal protective equipment and did not wear a gown during the observation.During an interview 01/14/2026 at 3:46 PM, Licensed Practical Nurse #8 stated Enhanced Barrier Precautions were initiated for residents that had foley catheters (insertion of tube to drain urine), infections such as urinary tract infection or wound infections. Licensed Practical Nurse #8 stated if a resident was on Enhanced Barrier Precautions there would be a sign posted on their door to alert them to what residents required precautions. They stated Resident #15 was not on Enhanced Barrier Precautions because there was no sign posted on their door. Licensed Practical Nurse #8 stated Resident #15 had unstageable pressure ulcers to both hips and there was a small amount of drainage noted during wound care. They were unsure if Resident #15 should have been on Enhanced Barrier Precautions for their wound.During an interview on 01/14/2026 at 3:51 PM, Certified Nurse Aide #13 stated they would look for signs posted on resident doors to identify what residents required Enhanced Barrier Precautions. They stated residents who had wounds or foley catheters were on Enhanced Barrier Precautions and they would need to wear gowns, gloves and masks when providing care to prevent infection. Certified Nurse Aide #13 stated Resident #15 did not have an Enhanced Barrier Sign on their door, they assisted the nurse in providing hands on care and did not wear a gown.During an interview on 01/14/2026 at 3:56 PM, the Inservice Instructor stated staff had been educated on Enhanced Barrier Precautions, they were to be utilized for any resident with an indwelling device, or wounds with an active infection. They stated if there was no active infection in the wound, Enhanced Barrier Precautions would not be indicated.During an interview on 01/14/2026 at 4:02 PM, Registered Nurse Manager #1 stated any resident with a draining wound would be placed on Enhanced Barrier Precautions. They stated that Enhanced Barrier Precautions would be important to protect staff and residents from the spread of infections. Registered Nurse Manager #1 stated that Resident #15 had unstageable pressure ulcers to both hips and were not on Enhanced Barrier Precautions because their wounds were dry and did not have drainage. They stated if Resident #15's wounds started to drain they would have expected the nursing staff to inform them so that proper precautions could be initiated. During the interview Resident Nurse Manager #1 reviewed the wound consultants notes from 01/06/2026 and 01/13/2026, they stated the wound consultant documented Resident #15's wounds had light serous drainage. Registered Nurse Manager #1 stated after they reviewed the Wound Consultant notes Resident #15 should have been placed on Enhanced Barrier Precautions for their wounds.During an interview on 01/16/2026 at 8:58 AM the Assistant Director of Nursing/Infection Preventionist stated Enhanced Barrier Precautions were utilized when a resident had an indwelling medical device, history of multidrug-resistant organisms (MDROs), or a chronic open wound. They stated if a resident had an unstageable pressure ulcer that was intact with no drainage Enhanced Barrier Precautions would not be required, additionally they stated once the wound opened or had drainage, they would expect that resident to be placed on Enhanced Barrier Precautions to prevent the risk of infection.During an interview on 01/16/206 at 9:26 AM, the Director of Nursing stated they expected Enhanced Barrier Precautions to be implemented for all wounds unless they were superficial. They stated an unstageable pressure ulcer was considered a significant wound and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not superficial. The Director of Nursing stated nurse managers and supervisors were responsible for initiating Enhanced Barrier Precautions when needed and expected staff to utilize the proper protective equipment when providing resident care to prevent the spread of infection form staff to resident. They stated Resident #15 had unstageable pressure ulcers and should have been on Enhanced Barrier Precautions.2. Resident #152 had diagnoses of dementia, chronic kidney disease, and adult failure to thrive (a state of decline that is caused by chronic concurrent disease). The Minimum Data Set, dated [DATE] documented the resident had severe cognitive impairment, was dependent on staff for toileting, and did not currently have any pressure ulcers, deep tissue injuries or venous/arterial ulcers.The Comprehensive Care Plan dated 12/07/2025, documented that Resident #152 was at risk for multidrug resistant organism infection due to a chronic wound. Interventions included but were not limited to, use of Enhanced Barrier Precautions with gown and gloves during high contact resident care activities. The resident had the potential for pressure ulcers due to decreased mobility, history of a right heel pressure and a left heel pressure injury on 11/19/2025; interventions included but were not limited to Enhanced Barrier Precautions.The Kardex dated 01/16/2026, documented Resident #152 required total lift transfers with two staff and was on Enhanced Barrier Precautions which included use of gown and gloves during high contact resident care activities that have been demonstrated to result in transfer of multidrug resistant organisms to hands and clothing of healthcare personnel.Review of a nursing Progress Note dated 01/09/2026 at 3:06 PM, documented for Resident #152 Enhanced Barrier Precautions were to remain in place due to the presence of a chronic wound.Review of a medical provider Progress Note dated 01/14/2026 at 10:11 AM, documented Resident #152 was being followed for a left heel unstageable pressure ulcer. The left heel wound had 100 percent stable eschar (dark dead tissue) with smaller wound dimensions today. Edges are lifting.During an observation on 01/16/2026 at 1:58 PM, Certified Nursing Aide #3 and #11 were observed providing incontinent care for Resident #152 without wearing gowns as required. Resident #152 had an Enhanced Barrier Precaution sign posted on their door, and a personal protective equipment storage bin located outside the room.During an interview on 01/16/2026 at 2:04 PM with Certified Nursing Aide #11, they stated they were aware a resident in the room was on Enhanced Barrier Precautions but did not don (put on) personal protective equipment because they believed Resident #152's roommate was on precautions. They acknowledged they should have checked the Kardex, and personal protective equipment, including a gown, was required to prevent cross contamination.During an interview on 01/16/26 at 2:12 PM with Certified Nursing Aide #3, they stated Resident #152 was placed on Enhanced Barrier Precautions due to having pressure ulcers and acknowledged forgetting to don personal protective equipment. They stated this was important to reduce cross contamination and they should have worn a gown for high contact care.During an interview 01/16/2026 at 2:44 PM with Licensed Practical Nurse #10, Unit 3 East Manager, they stated Certified Nursing Aide #3 and #11 should have worn personal protective equipment that included a gown while care was provided. They stated staff are expected to check door signage and the Kardex before care was provided.During an interview on 01/16/2026 at 2:54 PM with the Director of Nursing, they stated their expectation was for staff to review door signage and don personal protective equipment before providing care and personal protective equipment was provided in bins outside the resident's rooms. They stated Certified Nursing Aide #3 and #11 should have worn gloves, masks, and gowns during incontinent care because this was high contact care.10 NYCRR 415.19(a)(1,2)

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	01/16/2026

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record the facility did not provide a safe, clean, comfortable and homelike environment for two (2) (3 East and 4 West) of six (6) shower rooms. Specifically, the 3 East and 4 [NAME] shower rooms had issues that involved dirty floors and drains, and standing water on multiple days. Additionally, there were unlabeled personal care items were stored on the shelf in the 4 [NAME] shower room. Resident #223 was involved.The findings are: The procedure titled Cleaning Schedules: Housekeeping dated 04-16 documented a cleaning schedule is followed to control the spread of infection. Shower rooms were to be cleaned daily following the specific infection control directives, and the shower room walls were to be cleaned monthly. The procedure titled Cleaning Shower Rooms/Chairs: Housekeeping dated 11-16 documented shower rooms/chairs are cleaned daily to control the spread of infection. Shower and tub room cleaning included to disinfect and clean walls and doors (spot clean if visibly soiled), make sure floor area was free from dirt and debris and then mop. The procedure titled Infection Control Program dated 11/2024 documented the Infection Control Program establishes guidelines to follow to provide a safe, sanitary and comfortable environment, which helps to prevent the development and transmission of disease and infection. Three East Shower Room: Intermittent observations and interviews revealed the following: During an observation on 01/12/2026 at 11:30 AM a brown substance was observed on the floor in the first shower stall in the 3 East shower room. During an observation on 01/13/2026 at 9:50 AM the same brown substance remained on the shower room floor. During an observation on 01/13/2026 at 3:36 PM the brown substance was no longer visible on shower room floor. During an interview on 01/13/2026 at 3:36 PM, Certified Nurse Aide #15 stated if the substance was a bodily fluid, certified nurse aides, not maintenance, were responsible for cleaning it. They stated they did not provide showers on 01/12/2026 or 01/13/2026. They stated they were uncertain how often the shower room was cleaned but believed it should be disinfected between each resident to prevent cross contamination. During an interview on 1/14/26 at 3:09 PM, Certified Nursing Aide #16 stated it was important to keep the shower clean in between residents. They stated they would not want to take a shower in a dirty environment, and the shower room was part of the resident's home. During an interview on 01/16/2026 at 11:11 AM, Certified Nursing Aide #3 stated they saw the brown substance on the 3 East shower stall floors on 01/13/2026, believed it to be human feces and cleaned and disinfected the area immediately. They stated they did not know how long the substance had been present but stated the shower rooms are hot spots for germs and that some residents have open wounds, increasing the importance of cleanliness. Four [NAME] Shower Room: Intermittent observations and interviews revealed the following: -01/12/2026 at 10:35 AM, 01/14/2026 at 9:21 AM, and 01/15/2026 at 8:49 AM the first shower stall, nearest to hallway had three, eleven-ounce shaving creams opened and unlabeled; one, four-ounce tube of moisturizing body cream and one, four-ounce tube of skin guard unlabeled and used on the corner shelf. The second shower stall floor was wet, had standing water, and hair and a bandage covering the drain. Additionally, two, eight-ounce bottles of shampoo and body wash opened and unlabeled, three, three-ounce antifungal body powders, one, eleven-ounce shaving cream unlabeled were stored on corner shelf in the shower stall. -01/15/2026 at 10:06 AM, Resident #223 was seated in a shower chair in the second stall receiving assist with their shower. Certified Nurse Aide #7 was heard stating there was a flood in here. -01/15/2026 at 10:48 AM, Resident #223 stated that something was not draining right while they were in the shower. When asked how their shower was and they stated, come on, luke warm water, sitting on a stool with this much water on the floor, demonstrating with their fingers that the water was standing approximately a half inch on the shower floor. They stated it was not like taking a shower at home. -01/15/2026 at 10:54 AM, Certified Nurse Aide #7 stated they were responsible for cleaning up what supplies they brought into the shower room and wiping down the shower chair so that it was ready for the next residents' use. (continued on next page)

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	335112	A. Building B. Wing	01/16/2026

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	They stated they believed it was the housekeeper responsible for cleaning the shower room floors. They stated the floor did not look clean prior to giving Resident #223 a shower. They stated there was hair and a bandage blocking the drain. They stated the floor should have been cleaned prior to giving a shower for infection control purposes. They stated resident care items, shaving cream, powders, shampoo & body wash, creams should be labeled, so they know who they belong to and should not be used for another resident. -01/15/2026 at 11:04 AM, Licensed Practical Nurse #1 stated that the shower stall did not appear clean and sanitary because there was soap scum, hair over the drain, gauze bandage and what appeared to be stool (feces) smeared on the floor. They stated unlabeled personal care items should not be stored in the shower room and did not know who they belonged to. They stated it nobody should be using another resident's stuff. -01/15/2026 at 11:13 AM, Housekeeping/Laundry Supervisor stated it was the responsibility of the housekeeper to wash the shower floors and wipe down shower tiles every- day shift for safety and infection control purposes. They stated the shower floor looked dirty and needed to be scrubbed. They stated the shower room condition was not homelike. They stated residents deserved to take a shower in a clean shower room. Additionally, they stated personal care items should not be kept in the shower room, the aides were responsible for removing them. -01/15/2026 at 12:00 PM, Housekeeper #1 stated 4 [NAME] was their assigned floor. They stated it was their responsibility to check to see if the shower room floors were dirty, sweep, mop, wipe down shelves in the stalls. They stated they completed this as needed, sometimes everyday if needed. They stated the last time they mopped the shower room was last Wednesday (01/07/2026). They stated it was important that the shower room was cleaned because of germs. -01/15/206 at 12:05 PM, Housekeeper #1 observed the 4 [NAME] shower room and stated it needed to be cleaned, there was loose hair, dust bunnies over the drain; the brown tinged water (standing water) should not be there and looked like soap scum. They stated the shower stall was not sanitary and they should have cleaned it since last Wednesday. They stated they did not have a reason why they had not cleaned it and would take care of it. -01/16/2026 at 12:43 PM, the Director of Environmental Services stated they expected housekeepers to mop the shower room floors, spray down the walls to disinfect them daily. They stated it was important to keep the shower rooms clean, and homelike. 10 NYCRR 415.5(h)(2)