STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335164	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Humboldt House Rehabilitation and Nursing Center	64 Hager Street Buffalo, NY 14208

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observations, interviews, and record review conducted during the survey the facility failed to ensure that each resident had the right to be treated with respect and dignity for one (1) (Resident # 20) of three (3) residents reviewed. Specifically, Resident #20 was served their lunch meal when they were visibly incontinent. In addition, there were soiled linens, a large amount of fecal matter, and soiled briefs and linens on the floor between their bed and wall.The findings include:The policy and procedure titled Dignity dated 2/21 documented each resident shall be cared for in a manner that promotes their sense of well-being, and feelings of self-esteem. The residents are always to be treated with dignity and respect.Resident #20 had diagnoses that included cerebral vascular accident (stroke) Schizophrenia (a chronic severe brain disorder characterized by hallucinations and delusions) and intellectual disability. The Minimum Data Set (a resident assessment tool) dated 02/18/2026 documented Resident #20 was understood, understands and was severely cognitively impaired. There were no behaviors documented during the assessment period. Resident #20 required total assist of one (1) for personal hygiene and total assist of two (2) for toileting and was incontinent of bowel and bladder.The care plan report dated 03/03/2026 documented Resident #20 had a self-care deficit related to cerebral vascular accident and intellectual disability. Interventions included Resident #20 was independent with eating, total assistance of one (1) staff for personal hygiene and total assistance of two (2) staff for toileting. There was no care plan developed to address bowel and bladder incontinence.The Kardex (a guide used by staff to provide care) dated 03/27/2026 documented Resident #20 required total assistance of one (1) staff for personal hygiene and total assistance of two (2) staff for toileting. The Kardex did not give staff instructions regarding incontinent care needs.The following was observed on 03/25/2026:-12:29 PM Resident #20 was observed in bed with just an incontinent brief, a small blanket and a flat sheet covering the mattress. The flat sheet was visibly soaked/soiled with urine from their shoulders to the foot of their bed. Between the bed and the wall were three (3) soiled flat sheets and a soiled brief. There was a large amount of feces and dried food debris on the floor. Resident #20 was awake and did not respond when spoken to. -1:09 PM Resident #20 remained in bed and was still laying on the heavily soiled sheet. Between the bed and the wall on the floor the soiled linens and brief remained, as well as the large amount of feces and dried food debris. Resident #20's lunch tray was on the over bed table with hundred percent (100%) consumed. During an observation and interview on 03/25/2026 at 1:12 PM, Certified Nurse Aide #2 stated Resident #20 was on their assignment today, and that they had washed and provided incontinent care to the resident around 7:30 AM. Certified Nurse Aide #2 stated Resident #20 should be provided incontinent care every two (2) hours, they had not been back in the resident's room since this morning, and did not provide them their lunch tray. At this time, Resident #20 remained in bed laying on the heavily soiled sheet. Certified Nurse Aide #2 stated Resident #20 would remove their brief and pee and poop on the bed and put the soiled sheets and brief on the floor. Certified Nurse Aide #2 removed the soiled sheets and brief from behind the bed and stated they would get a housekeeper to clean up the floor. They said it was not like this when they washed Resident #20 up this morning. Resident #20 must have pushed them onto the floor. Certified Nurse (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aide #2 also stated that Resident #20 should have been cleaned up before receiving their lunch.- 2:15 PM Resident #20 was sleeping in bed, the linens on the bed were changed but the dried food debris and large amount of feces remained on the floor behind the bed.Review of the video surveillance footage provided by the facility on 03/26/2026 at 9:51 AM revealed Certified Nurse Aide #2 entered Resident #20's room with the resident's lunch tray on 3/25/2026 at 12:50 PM, exited the room at 12:51 PM and closed the door.During a follow- up interview on 03/26/2026 at 12:47 PM, Certified Nurse Aide #2 stated they could not recall if they gave Resident #20 their lunch tray yesterday (03/25/26), but Resident #20 should have been cleaned up and linens change prior to receiving their lunch tray. No resident should be left that way to eat and it was a dignity issue. Durning an interview on 03/26/2026 at 1:44 PM, Registered Nurse Unit Manager #2 stated Resident #20 should have been provided care prior to receiving their lunch tray, and it was undignified. Durning a telephone interview on 03/27/2026 at 11:03 AM, Resident #20's family member stated Resident #20 was always soiled with feces and urine when they come in to visit. It's not right Resident #20 should not be treated or cared for that way. The staff don't care, and they have complained to the social workers and the nurses, but nothing ever changes. It's terrible. Durning an interview on 03/27/2026 at 1:04 PM, the Corporate Director of Nursing stated incontinent care should be completed every 2-3 hours. Resident #20 should have been provided with care and their room cleaned before the resident was served their lunch. 10 New York Code Rules Regulations 415.3 (a)

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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 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. Based on observations, interviews, and record review conducted during the survey the facility failed to ensure that each resident who was unable to carry out Activities of Daily Living (ADL's) received the necessary services to maintain grooming and personal hygiene for one (1) (Residents #20) of three (3) residents reviewed. Specifically, Resident #20 was not provided with incontinent care every two (2) to three (3) hours and was not provided with timely incontinent care prior to lunch being served. Additionally, a care plan was not developed for bowel and bladder incontinence. The findings include:The policy and procedure titled Perineal Care dated 2/2018 documented the purpose of this procedure was to provide cleanliness and comfort to the residents, to prevent infection and skin irritation.Resident #20 had diagnoses that included cerebral vascular accident (stroke) Schizophrenia (a chronic severe brain disorder characterized by hallucinations and delusions) and intellectual disability. The Minimum Data Set (a resident assessment tool) dated 02/18/2026 documented Resident #20 was understood, understands and was severely cognitively impaired. There were no behaviors documented during the assessment period. Resident #20 required total assist of one (1) for personal hygiene and total assist of two (2) for toileting and was incontinent of bowel and bladder.The care plan report dated 03/03/2026 documented Resident #20 had a self-care deficit related to cerebral vascular accident and intellectual disability. Interventions included that Resident #20 was independent with eating, total assist of one (1) staff for personal hygiene and total assistance of two (2) staff for toileting. There was no care plan developed to address bowel and bladder incontinence.The Kardex (a guide used by staff to provide care) dated 03/27/2026 documented Resident #20 required total assistance of one (1) staff for personal hygiene and total assistance of two (2) staff for toileting. The Kardex did not give staff instructions regarding incontinent care needs. Review of the Progress Notes dated 3/25/2026 revealed there was no documented evidence Resident #20 refused care.The following was observed on 03/25/2026:-12:29 PM Resident #20 was observed in bed with just an incontinent brief, a small blanket and a flat sheet covering the mattress. The flat sheet was visibly soaked/soiled with urine from their shoulders to the foot of their bed. Between the bed and the wall were three (3) soiled flat sheets and a soiled brief. There was a large amount of feces and dried food debris on the floor. Resident #20 was awake and did not respond when spoken to. -1:09 PM Resident #20 remained in bed and was still laying on the heavily soiled sheet. Between the bed and the wall on the floor the soiled linens and brief remained, as well as the large amount of feces and dried food debris. Resident #20's lunch tray was on the over bed table with hundred percent (100%) consumed. During an observation and interview on 03/25/2026 at 1:12 PM, Certified Nurse Aide #2 stated Resident #20 was on their assignment today, and that they had washed and provided incontinent care to the resident around 7:30 AM. Certified Nurse Aide #2 stated Resident #20 should be provided incontinent care every two (2) hours, they had not been back in the resident's room since this morning, and did not provide them their lunch tray. At this time, Resident #20 remained in bed laying on the heavily soiled sheet. Certified Nurse Aide #2 stated Resident #20 would remove their brief and pee and poop on the bed and put the soiled sheets and brief on the floor. Certified Nurse Aide #2 removed the soiled sheets and brief from behind the bed and stated they would get a housekeeper to clean up the floor. They said it was not like this when they washed Resident #20 up this morning. Resident #20 must have pushed them onto the floor. Certified Nurse Aide #2 also stated that Resident #20 should have been cleaned up before receiving their lunch.- 2:15 PM Resident #20 was sleeping in bed, the linens on the bed were changed but the dried food debris and large amount of feces remained on the floor behind the bed.Review of the video surveillance footage provided by the facility on 03/26/2026 at 9:51 AM revealed Certified Nurse Aide #2 entered Resident #20's room with the resident's lunch tray on 3/25/2026 at 12:50 PM, exited the room at 12:51 PM and closed the door.During a follow- up interview on 03/26/2026 at 12:47 PM, Certified Nurse Aide #2 stated they could not recall if they gave Resident #20 their lunch tray (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	yesterday (03/25/26), but Resident #20 should have been cleaned up and linens change prior to receiving their lunch tray. Durning an interview on 03/26/2026 at 1:44 PM, Registered Nurse Unit Manager #2 stated Resident #20 was incontinent of bowel and bladder and required total assist for care. Resident #20 could be resistive with care, and they were not aware Resident #20 was incontinent. Resident #20 should be provided with incontinent care every two (2) to three (3) hours. Registered Nurse Unit Manager #2 stated they were unsure if Resident #20 was care planned for bowel and bladder incontinence/care and they were trying to catch up on all the residents' care plan documentation. Resident #20 should have been provided care prior to receiving their lunch tray.Durning a telephone interview on 03/27/2026 at 11:03 AM, Resident #20's family member stated Resident #20 was always soiled with feces and urine when they come in to visit. Durning an interview on 03/27/2026 at 1:04 PM, the Corporate Director of Nursing stated incontinent care should be completed every two (2) to three (3) hours. Resident #20 should have been cleaned up and their room cleaned before they were served their lunch. It's an infection control issue. The Corporate Director of Nursing stated the facility does not document ADL (activities of daily living) completion. 10 New York Code Rules Regulations 415.12 (a)(3)

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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. Based on observations, interviews, and record review conducted during the survey, the facility failed to ensure that residents who had an indwelling Foley catheter (tube inserted into the bladder to drain urine) received the appropriate care and services to manage catheters for one (1) (Resident #19) of three (3) residents reviewed for Foley catheters. Specifically, Resident #19 had a history of urinary tract infections, and the urine collection bag was observed lying directly on the floor on multiple occasions. Additionally, infection control practices were not maintained while emptying the urine collection bag and staff did not utilize enhanced barrier precautions (interventions designed to reduce transmission of multi-drug-resistant organisms including gown and glove use during high contact resident care activities) when providing direct hands-on care.The findings include: The policy and procedure titled Urinary Catheter Care dated 8/2022 documented that catheter tubing and drainage bag were to be kept off the floor, the collection bag was to be emptied at least every eight (8) hours, to avoid splashing, and to prevent contact of the drainage spigot with the non-sterile container. The policy and procedure titled Enhanced Barrier Precautions dated 12/2024 documented enhanced barrier precautions were utilized to prevent the spread of multi-drug-resistant organisms to residents during high contact resident care. Furthermore, the policy and procedure documented examples of high contact resident care activities that required the use of gown and gloves or enhanced barrier precautions included central lines, urinary catheters, and feeding tubes. Resident #19 had diagnoses that included quadriplegia (paralysis of all four limbs), chronic kidney disease, and depression. The Minimum Data Set (a resident assessment tool) dated 12/01/2025 documented that resident was cognitively intact and had an indwelling catheter. The Care Plan Report dated 11/29/2024 documented Resident #19 had a Foley catheter. Documented interventions included monitoring for signs and symptoms of urinary tract infection and report to the Doctor of Medicine, and to position the drainage bag and tubing below the level of the bladder. The Kardex (a guide used by staff to provide care) dated 03/27/2026 documented to provide Foley catheter care every shift and monitor/document Foley output every shift. Observations of Resident #19 on 03/26/2026 revealed the following: - 8:55 AM, the Resident was sleeping in bed, and their breakfast tray was untouched on the bedside table. The Resident's urinary drainage bag had approximately one thousand (1,000) milliliters of amber colored urine and was lying on directly on floor under the bed. The drainage tubing contained urine and a large amount of white mucous. Licensed Practical Nurse #1 entered the Resident's room to administer their medications and exited the room. Their urinary drainage bag remained on the floor. - 9:10 AM, Licensed Practical Nurse #1 entered the Resident's room, fed the Resident breakfast, and exited the room when the task was completed. Their urine drainage bag remained on the floor. - 10:16 AM and 11:26 AM, their urinary drainage bag remained on the floor. During an interview on 03/26/2026 at 11:31 AM, Certified Nurse Aide #3 stated Resident #19's urinary drainage bag should not have been on the floor as it was an infection control issue and should have been emptied because it was full. During an interview on 03/26/2026 at 11:48 AM, Licensed Practical Nurse #1 stated they were Resident #19's nurse today. They stated hey gave the Resident their medications and fed the Resident their breakfast this morning. Licensed Practical Nurse #1 stated they did not recall if the urinary drainage bag was on the floor when they gave the Resident their medications and fed the Resident their breakfast at the time. Licensed Practical Nurse #1 further stated the urinary drainage bag should not have been on the floor as it was an infection control issue and the Resident was prone to having urinary tract infections. During an observation on 03/26/2026 at 11:50 AM there was a sign posted on the door that Resident #19 required enhanced barrier precautions, and it was noted that supplies where nearby and available. Certified Nurse Aide #3 entered Resident #19's room, donned (put on) gloves, picked up the urinary drainage bag off the floor, and placed the clean urinal they brought into the room directly on the floor with no barrier. Certified Nurse Aide #3 subsequently (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opened the urinary drainage bag spigot and filled the urinal to the top. Certified Nurse Aide #3 then placed the urinary drainage bag with the spigot opened back on the floor, proceeded to the Resident's bathroom, and emptied the urine in the urinal into the toilet. Certified Nurse Aide #3 then placed the urinal back directly on the floor and finished emptying the urine from the urine drainage bag into the urinal and replaced the spigot into the bag holder without cleaning the spigot tip with alcohol. Certified Nurse Aide #3 was not wearing a protective gown while emptying the urinary drainage bag. During an interview at the time of the observation, Certified Nurse Aide #3 stated the Resident had eighteen hundred (1,800) milliliters emptied from the urinary drainage bag and was on enhanced barrier precautions because they had a Foley catheter. During an interview on 03/26/2026 at 1:21 PM, the Registered Nurse Infection Preventionist stated they had been with the facility for approximately two (2) weeks and were not familiar with the facility policy and procedures or the residents. The Registered Nurse Infection Preventionist stated urinary drainage bags should never be on the floor as it was an infection control issue and put the resident at risk for urinary tract infections. During an interview on 03/26/2026 at 1:30 PM, the Director of Nursing stated they would expect staff to follow enhanced barrier precautions for a resident with a Foley catheter. Precaution signs were on the residents' room doors to remined staff. The urinary drainage bag should never be on the floor, the bag should be emptied every shift, and staff should document the output. During an interview on 03/27/2026 at 1:05 PM, Registered Nurse Unit Manager #1 stated Resident #19 had a Foley catheter related to neurogenic problems. The Resident had a history of urinary tract infections and was just treated in February. The urinary drainage bag should never be on the floor, and they would expect the staff to wear a gown and gloves when emptying the urinary drainage bag per enhanced barrier precautions protocol. During an interview on 03/27/2026 at 1:15 PM, the Corporate Director of Nursing stated they would have expected the staff to follow enhanced barrier precautions, and don (put on) gloves and a gown when emptying the urinary drainage bag. The urinary drainage bag should not be on the floor as it was an infection control issue, and a barrier should have been used. 10 New York Code Rules and Regulations 415.12(d)(1)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review conducted during the survey the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, observations of one (1) of one (1) kitchen revealed an active ceiling leak in front of the walk-in refrigeration and freezer units, several missing and broken wall tiles, the commercial oven range was soiled with grease and food debris, the wall behind the stove, oven, and two (2) bay sink was heavily soiled with grease, the drain pipe underneath the hand wash sink leaked, the paper towel dispenser by the hand wash sink was non-working, and ceiling pipes were covered with dust. Additionally, the walk-in freezer had black debris around the window, a broken gasket, and accumulated condensation and ice buildup on the exterior and interior door surfaces, the floor, and ceiling. The findings include: The policy titled Sanitation dated October 2008 documented the food service area shall be maintained in a clean and sanitary manner. All equipment, food contact surfaces and utensils must be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water or chemical sanitizing chemicals. Kitchen surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. The policy titled Food Receiving and Storage dated October 2017 documented foods shall be received and stored in a manner that complies with safe food handling practices. Food services, or other designated staff, will maintain clean food storage areas at all times. Durning intermittent observations on 03/23/2026 at 9:15 AM, 03/23/2026 at 11:46 AM, 03/25/2026 at 11:19 AM, and 03/26/2026 at 9:01 AM of the kitchen, the following was revealed: -the walk-in freezer and cooler area adjacent to the air conditioning ventilation duct contained an approximate three (3) foot by two (2) foot opening in the plaster ceiling. Below the opening was an approximate four (4) foot by four (4) foot tarp suspended from the ceiling by the tarp's four (4) eyelet holes. The tarp had a water drain hose from its center that directed water into the drain on the floor. -the air conditioner ventilation unit, approximately two (2) foot by two (2) foot wide adjacent to the tarp, was actively leaking water onto the floor. The floor in front of the walk-in freezer and cooler units had approximately one-sixteenth (1/16) of an inch of standing water pooled in an approximate ten (10) foot by eight (8) foot wide area. -(3/23/26) a tray catty with approximately (13) food covers and plate warmers on top of the catty was stationed under the tarp connected to the ceiling and the actively dripping air conditioning ventilation unit. -(3/25/26) two (2) tray catties with approximately forty (40) food covers on top of the catties stationed under the tarp connected to the ceiling and the actively dripping air conditioning ventilation unit. -a four (4) tier metal shelf extended underneath the tarp and contained multiple uncovered condiments, salt packets, pepper packets, sugar packets, creamer packets, and four (4) containers of peanut butter. -there was approximately one-half (0.5) of an inch of gray dusty debris on the pipes attached to the ceiling throughout the kitchen, including areas above food preparation stations and food serving stations. -the hand wash sink next to the kitchen entry door had an active drainpipe leak when in-use. The hand wash sink contained an approximate six (6) inch stack of paper towels that were partially wet and above the sink was a non-working paper towel dispenser. -the wall behind the stove, oven, and two (2) bay sink was soiled with dark black thick grease and food debris and contained pieces of broken wall tile. -all exterior surfaces of the commercial oven range were heavily coated with grease and food debris. - the walk-in freezer door gasket was not securely attached and protruded through the space between the door and the freezer unit. Additionally, the walk-in freezer had black debris on the window, condensation and ice buildup on the lower exterior and interior sides of the door, and an approximate two (2) foot by one (1) foot accumulation of ice inside the unit on the floor and ceiling. - the wall behind the stove and oven, and the window above the two (2) bay sink, had broken and missing wall tiles. The damaged area behind the stove and oven measured approximately three (3) foot by two (2) foot and included peeled plaster. The damaged area (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	above the two (2) bay sink had approximately seven (7) missing tiles and peeled plaster. During an interview on 03/23/2026 at 10:10 AM, the Food Service Director stated they worked with the facility for about one (1) year. The ceiling in the kitchen had leaked since they started and became worse since the snow started. The Food Service Director stated they reported the leak to administration and believed estimates were made but were unsure if anything had been done to fix it. The Food Service Director also stated the leak was worse today with the rain. Durning an interview on 03/23/2026 at 10:23 AM, the Administrator stated the issues with the ceiling in the kitchen started with the heavy snow and were patched by the facility two (2) times prior. Additionally, the Administrator stated the leak was located on the single-story part of the roof above the kitchen around the air conditioning unit, it looked like someone patched the area in the past, and they tore part of the ceiling down in the kitchen to see what was going on. The Administrator further stated the facility obtained estimates sometime in October 2025 and they were waiting for the weather to break before they could repair it. During an interview on 03/25/2026 at 1:01 PM, the [NAME] stated the stove should be cleaned after each meal including the top and all sides. The stove did not look like it was cleaned after breakfast as there was still pancake batter on the side of the stove. They were unaware of the missing tiles behind the stove and window. Additionally, the [NAME] stated the leak in the ceiling near the walk-in freezer and cooler units had been that way since they started at the facility in December 2025 and leaked more when it rained or snowed. The [NAME] also stated they did not notice the dust on the pipes connected to the ceiling and the pipes should be cleaned as they were over food prepping stations and could fall on prep surfaces. The [NAME] further stated they were unsure how long the paper towel dispenser was not working near the hand wash sink and the paper towels on the sink were wet and should not be used to dry staff hands. During an additional interview on 03/26/2026 at 1:09 PM, the Food Service Director stated the condiments, open boxes, and containers should be closed, covered, and not stored under the tarp and leaking air conditioning ventilation unit. Additionally, they stated the catties should not be stored under the leaking ceiling, it was an ongoing problem, and staff were reminded about the issue. Furthermore, they stated the gasket on freezer door needed to be replaced because it had a tear and the door did not seal properly. The Food Service Director stated the freezer had been fixed at least three (3) to four (4) times in the past year because of condensation and ice buildup inside the freezer. They stated the tiles on the back wall of the kitchen fell off as they were being cleaned today, and the Administrator was notified of the issue and stated the tiles would be fixed. Finally, the Food Service Director stated the stove should be cleaned after each meal, the evening cook had a problem with cleaning it correctly, and the front and sides were dirty and needed to be cleaned. During an interview on 03/27/2026 at 10:03 AM, the Maintenance Supervisor stated the roof was leaking for about the last six (6) months near the air conditioning unit above the kitchen. Additionally, they stated they pulled down part of the ceiling in the kitchen in September last year to identify the problem. Furthermore, they stated the roof was patched in September and again in November because the area continued to leak, and the facility planned on having the roof repaired when the weather broke. The Maintenance Supervisor stated they were aware of the broken and missing wall tiles, there had been an issue since the middle of 2025, and more tiles fell off behind the oven yesterday. They also stated they were unaware of the broken gasket on the walk-in freezer, and it should be replaced. The Maintenance Supervisor further stated the freezer door was worked on about 3 months ago and they were unsure if the broken gasket was causing the condensation and ice buildup inside and outside of the unit. Durning an interview on 03/27/2026 at 1:24 PM, the Administrator stated they were aware of the current and ongoing issues in the kitchen. They stated the facility planned to fix the ceiling in the kitchen and roof leak when the weather broke. Additionally, the Administrator stated they were unaware the tray catties and condiments were stored in the area of the leaking ceiling, and the wall tiles would be fixed. 10 New York Code Rules Regulations 415.14(h)