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	06/09/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a survey, the facility failed to ensure the resident's right to be free from physical abuse by staff for one (Resident #1) of three residents reviewed. Specifically, based on facility surveillance footage, facility investigation, and an eyewitness account, a certified nurse aide was physically abusive to Resident #1. This is identified as past noncompliance The findings include: The undated facility policy titled Resident Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure documented residents have the right to be free from abuse and associates must not use physical abuse against any resident. The facility explicitly and expressly prohibits and will take steps to prevent any associates from engaging in any behavior or actions that may result in the abuse of residents. In response to any allegations of abuse or mistreatment the facility will ensure all alleged violations involving abuse are reported in the proper timeframe. Resident #1 had diagnoses including dementia, anxiety, and hypothyroidism (the thyroid gland does not produce enough hormones causing the body's metabolism to slow down). The Minimum Data Set (a resident assessment tool) dated 04/08/2026 documented the resident had severe cognitive impairment, had verbal behavioral symptoms directed towards others, had no physical behavioral symptoms and did not wander. The comprehensive care plan dated 04/20/2026 documented Resident #1 was a wanderer and was at risk for victimization related to severe dementia. Interventions included encouraging the resident to attend activities, especially in the afternoons at shift change, moving to a less stimulating environment, and to redirect away from other resident's rooms as needed. The Kardex (a guide used by staff to direct care) dated 06/09/2026 documented staff were to engage the resident in activities as needed and as follows especially at shift change, redirect away from other resident's rooms, move to a less stimulating area as needed. Review of the facility's video footage (no audio available) on 06/09/2026 at 8:50 AM with the Director of Nursing and Administrator present, revealed the footage was timestamped 06/02/2026 and the Administrator stated it was from the short hall on the 4th floor. At 1:11:17 PM, Housekeeper #1 was seen walking from the direction of the nurse's station to Resident #2's room (a private occupied room), they were going into the room as Certified Nurse Aide #1 exited a different room at the end of the hallway and walked toward Resident #2's room. It appeared Housekeeper #1 said something to the Certified Nurse Aide #1 and then went into Resident #2's room. Certified Nurse Aide #1 went into the room after Housekeeper #1 at 1:11:46. While the staff members were entering that room, Resident #1 was seen walking from the direction of the nurse's station toward Resident #2's room. At 1:11:52 PM, Resident #1 stopped at the doorway to Resident #2's room, looked into the room, then entered the room. At 1:12:10 PM, Resident #1 was seen falling backwards from inside Resident #2's room, attempting to brace themselves with their left hand as they fell, landing on their buttocks and then onto their back on the floor in the middle of the hallway. During an interview at this time, the Administrator stated the timestamp on the footage was off by one hour due to daylight savings time and this footage was from the two o'clock hour not the one o'clock hour. The Nursing Home Investigative Report: Submission #24768 submitted on 06/09/2026 at 9:52 AM, documented an incident date of 06/02/2026 at 2:00 PM (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Housekeeper #1 witnessed Certified Nurse Aide #1 swear at Resident #1 and push them out of a room causing them to fall. Certified Nurse Aide #1 denied yelling or swearing at the resident and said they tried to redirect the resident out of the room. Certified Nurse Aide #1 said the resident fell and they did not help them up or report the fall. Law enforcement was notified, and an investigation was ongoing at their end. The facility concluded that the findings were verified and there was reasonable cause to believe that abuse, neglect, or mistreatment occurred. Review of a written statement signed by Housekeeper #1 dated 06/03/2026 revealed they were cleaning in Resident #2's room and Resident #2 asked to see a nurse, so they went to the front desk, and a staff member who was short and skinny went to the room to see the resident. Before they were done cleaning the room the resident asked to see a nurse again. They came and a resident came in behind them. The resident had curly greyish/black hair. The aide pushed them backward and said, get the (expletive) out of my face and pushed them backward. The resident fell and hit the floor. Clarification: they heard the resident hit the floor, they were cleaning from the bathroom and did not witness the fall, but they saw the staff member pushing the resident. Review of a written statement signed by Certified Nurse Aide #1 and dated 06/03/2026 revealed they saw Resident #1 in a resident's room, and they entered the room to redirect the resident. Resident #1 became combative, and they directed the resident by their arm to the doorway and then Resident #1 threw themselves on the floor outside the door. While the resident was on the floor, they were going to reapproach but the resident was still being combative and so they continued to walk up the hall. The only people in attendance were Certified Nurse Aide #1 and Resident #1. During an observation on 06/09/2026 at 10:02 AM, Resident #1 was in the unit lounge area sitting in a chair by the television. They were alert and able to tell me their name but could not answer any other questions. The resident was wearing shorts and a T-shirt and had no visible injuries. During an interview on 06/09/2026 at 10:09 AM, Resident #2 was in their room lying in bed watching television. They stated they think a staff member was in their room and that Resident #1 was trying to come into their room. The staff member did not want the other resident in their room. The resident stated they did not know if the staff member pushed or cursed at Resident #1 or if the resident fell as they were not paying attention. Resident #2 could not remember when this occurred. During a telephone interview on 06/09/2026 at 10:26 AM, Certified Nurse Aide #1 stated they worked on 06/02/2026 on the 4th floor and had just left a resident's room and saw Resident #1 in the room across the hallway standing near a resident's dresser. They did not know the exact room number, but they did know it was Resident #3's room. They went into the room to direct Resident #1 out and the resident threw themselves out of the room. Certified Nurse Aide #1 stated she had grabbed the resident's arm and directed them toward the door and as they put Resident #1 toward the door, the resident threw themselves out of the room backwards and went ah ah with their hands up. The Certified Nurse Aide #1 stated they saw the resident land on the floor on their bottom like as they sat down. Certified Nurse Aide #1 stated the resident was not hurt and they did not help the resident up because they were being combative, but they did see Resident #1 attempt to get up but did not actually see them get up because they were walking away from the resident. The Certified Nurse Aide #1 stated they were not in Resident #2's room, they were in the room behind it toward the fire door direction which was Resident #3's room. The Certified Nurse Aide #1 stated before they directed Resident #1 out of the room, they told the resident to get out of (Resident #3's) room, they did not yell or swear at the resident. Then they had Resident #1's arm and directed them toward the door. Certified Nurse Aide #1 stated there was no resident in the room at the time of this incident. Certified Nurse Aide #1 stated they did not push Resident #1, and they would not do that to a resident. During further telephone interview on 06/09/2026 at 2:41 PM, Certified Nurse Aide #1 stated they did not report to anyone that Resident #1 fell because they knew the resident was not injured and was getting themselves up off the floor. Resident #1 was moving by themselves and did not have any injuries, so they did not think they needed to get a nurse. Certified Nurse Aide #1 stated they did not see any video footage and was unaware there was footage. Certified Nurse Aide #1 stated this (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident happened in Resident #3's room and it was not in Resident #2's room. They stated Resident #2 never left their room, that's how they knew it was Resident #3's room because nobody was in the room during the time of this incident. During a telephone interview on 06/09/2026 at 11:22 AM, Housekeeper #1 stated they were on the 4th floor cleaning a room. The resident (#2) in the room asked them to get a nurse, so they went to the front desk to ask for a nurse. A short, skinny brown skinned lady came into the room and saw the resident and left the room. Housekeeper #1 went out to their cart and the resident (#2) asked for a nurse again. The housekeeper went back to the desk, and the same person came to the room, and a resident (#1) followed them. The nurse pushed that resident backwards and said, get the (expletive) out of my face. Housekeeper #1 stated they were in the bathroom cleaning the floor at the time and did not see the resident (#1) fall but heard them fall. Resident (#2) was in their bed at this time. Housekeeper #1 stated they were not sure if the staff member was a nurse or an aide. Resident #2 asked for a nurse so they thought the staff member was a nurse, but they could have been an aide. Housekeeper #1 stated the staff member did not say anything else to the resident (#1) before swearing at them. Housekeeper #1 stated they did not see the resident (#1) fall but did see the staff member push the resident (#1) using two hands like they were hurrying the resident to get out of the room. After it happened the staff member talked to Resident #2 but then left the room. Housekeeper #1 stated they did not say anything to the staff member because they did not know them, but they should have said something because they felt it was wrong. Housekeeper #1 stated this happened around 2:00 PM. Housekeeper #1 stated they did not tell anyone until after they got home because they were scared. They stated they called their boss (Director of Housekeeping) around 4:00 PM. They did not report it right away because they were kind of fearful. Housekeeper #1 stated their boss told them they wished they would have reported it sooner. Housekeeper #1 stated they got in-service education about reporting incidents when they first started almost a year ago. During an interview on 06/09/2026 at 1:09 PM, Certified Nurse Aide #2 stated they were assigned to Resident #1 on 06/02/2026 and were not aware that someone pushed the resident or that the resident fell on the floor. They found out about it when they were asked for a statement. They stated Resident #1 could sometimes flail their arms during incontinent care and they had a staggered walk but did not throw themselves on the floor. The Certified Nurse Aide #2 stated pushing a resident was considered abuse. During an interview on 06/09/2026 at 1:17 PM, the Registered Nurse Unit Manager #1 stated they were not aware Resident #1 was pushed or that they fell on the floor. They stated they assessed the resident the day after the incident, and they had no injuries or no change in behavior. They stated they saw the video footage and felt there was some force there, lets be honest. They considered a staff member pushing a resident physical abuse. The Registered Nurse Unit Manager #1 stated they were not sure if Resident #1 had any history of throwing themselves on the floor, but they were a little unsteady. The Registered Nurse Unit Manager #1 stated if a staff member witnessed a push or any abuse, they were supposed to notify the Administrator or their department head so that they can tell administration. The timeframe to report was two (2) hours. During a telephone interview on 06/09/2026 at 2:17 PM, the Director of Housekeeping stated Housekeeper #1 called them at home on [DATE] around 4:00 PM. Housekeeper #1 stated they witnessed something but did not want to say anything because they were afraid of retaliation. The Director of Housekeeping told Housekeeper #1 they needed to tell them about it. Housekeeper #1 reported they witnessed one of the aides push one of the residents down. Housekeeper #1 did not know the name of the staff member or the resident involved as they were not on their usual floor. The Director of Housekeeping stated they told Housekeeper #1 they would have to go into the facility, but they said they could not go back to the facility but would go in the next morning. The Director of Housekeeping stated they told the Housekeeper #1 it would have to be reported within 24 hours. The Director of Housekeeping stated they did not notify the Administrator or Director of Nursing at that time because Housekeeper #1 was timid and seemed confused about what they witnessed and what time it happened and wanted to talk to them to get the correct information. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Housekeeping stated they reported this to the Director of Nursing the next morning. They stated they thought it had to be reported within 24 hours but had Housekeeper #1 reported it before they left work that day, it would have been reported on time. During an interview on 06/09/2026 at 3:06 PM, the Director of Nursing stated on the morning of 06/03/2026 the Director of Housekeeping told them that Housekeeper #1 said a resident was pushed the day before but that the housekeeper was confused and did not have their facts straight and was supposed to come into the facility that day. The Director of Nursing called Housekeeper #1, and they told them when they were cleaning in a resident room, the resident had asked for a nurse twice. The same staff member went into the room both times. The second time a resident wandered into the room behind them. Housekeeper #1 reported that while they were cleaning the bathroom the ?nurse' swore at the resident and pushed them. The Director of Nursing stated Housekeeper #1 did not know the staff member's name or the resident's name, but they had a thought on which resident it was based on the housekeeper's description of them. The Director of Nursing reported it to the Administrator right away and started an investigation. They assessed Resident #1 who was sitting in their bed, appeared to have no pain and no distress. They checked the resident's skin for bruises or markings, and they had none. Then they checked the video footage to confirm it was Resident #1 involved. The footage also confirmed it was Housekeeper #1 and Certified Nurse Aide #1 involved. Their investigation concluded that abuse occurred, that the Certified Nurse Aide #1 pushed the resident and they fell to the ground. The Certified Nurse Aide #1 did not report the fall either. The Director of Nursing stated Resident #1's right to be free from abuse was not followed by Certified Nurse Aide #1 and when they questioned the involved aide they got loud and defensive and immediately responded that Resident #1 was being dramatic and threw themselves on the floor. The Certified Nurse Aide #1 insisted nobody else was in the room when this happened and that they were in a different room from what the video showed. During an interview on 06/09/2026 at 3:37 PM, the Administrator stated they concluded that the Housekeeper #1's statement of Certified Nurse Aide #1 pushing Resident #1 seemed very factual and that abuse did occur. They had law enforcement involved, so yes, they believed abuse occurred. They stated the residents' right to remain free from abuse was not maintained and every mandated reporter should be ensuring residents remained free from abuse. The staff involved did not have any record of disciplinary actions, was not overworking, and staffing was good that day, but maybe they had a short fuse. The following corrective actions were implemented by the facility to correct the non-compliance as of 06/06/2026. -Certified Nursing Assistant #1 was removed from resident contact on 06/03/2026.-Resident #1 was assessed by nursing, medical, and social work staff and no ill effects were noted. The resident's care plan was reviewed.-During the abbreviated survey completed 06/09/2026 Resident #1 had no signs of abuse observed.-Starting on 06/04/2026 all facility staff were re-educated on resident rights, abuse and abuse reporting.-During the abbreviated survey completed 06/09/2026, it was verified through staff interviews and record review that the facility had re-educated 100% of their staff on abuse which included types of abuse and abuse reporting process including timeframes.-During the abbreviated survey completed 06/09/2026, it was verified through staff interviews and record review that on 06/04/2026 incident reports were reviewed dating back to 03/02/2026 for reporting timeframes and abuse instances by the Director of Strategic Planning. Certified Nurse Aide #1's file was reviewed with no prior discipline or incidents and had the required abuse education. 10 New York Codes, Rules, and Regulations 415.3(d)(1)(vii)

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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 conducted during a survey, the facility failed to ensure that all alleged violations involving abuse are reported immediately but not later than two hours after the allegation is made if the events that cause the allegation involve abuse, to the Administrator of the facility and to other officials (including to the State Survey Agency) for one (Resident #1) of three residents reviewed. Specifically, an allegation of staff to resident verbal and physical abuse was not reported to the facility Administrator and to the New York State Department of Health within the required two-hour timeframe. This is identified as past noncompliance. The findings include:Refer to F 600 Freedom from Abuse and Neglect, scope and severity DThe undated facility policy titled Resident Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure documented residents have the right to be free from abuse and associates must not use physical abuse against any resident. In response to any allegations of abuse or mistreatment the facility will ensure all alleged violations involving abuse are reported in the proper timeframe. When the facility has identified abuse, the facility will report the alleged violation within required timeframes pursuant to Federal and State statutes and regulations.Resident #1 had diagnoses including dementia, anxiety, and hypothyroidism (the thyroid gland does not produce enough hormones causing the body's metabolism to slow down). The Minimum Data Set (a resident assessment tool) dated 04/08/2026 documented the resident had severe cognitive impairment, had verbal behavioral symptoms directed towards others, had no physical behavioral symptoms and did not wander.Review of the Internet Quality Improvement and Evaluation System (iQIES) Complaint/Incident Investigation Report dated 06/03/2026 at 10:56 AM revealed an allegation of staff physical abuse involving Resident #1 occurred on 06/02/2026 at 1:00 PM. The Administrator was first made aware of the incident on 06/03/2026 at 8:30 AM.During a telephone interview on 06/09/2026 at 11:22 AM, Housekeeper #1 stated they were on the 4th floor cleaning a room and they saw a nurse push a resident backwards and say, get the (expletive) out of my face. Housekeeper #1 stated they were in the bathroom cleaning the floor at the time and did not see the resident fall but heard them fall. Housekeeper #1 stated they were not sure if the staff member was a nurse or an aide. Resident #2 asked for a nurse so they thought the staff member was a nurse, but they could have been an aide. Housekeeper #1 stated the staff member did not say anything else to Resident #1 before swearing at them. Housekeeper #1 stated they did not see the resident fall but did see the staff member push the resident using two hands like they were hurrying the resident to get out of the room. Housekeeper #1 stated they did not say anything to the staff member because they did not know them, but they should have said something because they felt it was wrong. Housekeeper #1 stated this happened around 2:00 PM. Housekeeper #1 stated they did not tell anyone until after they got home because they were scared. They stated they called their boss (Director of Housekeeping) around 4:00 PM. They did not report it right away because they were kind of fearful. Housekeeper #1 stated their boss told them they wished they would have reported it sooner. Housekeeper #1 stated they got in-service education about reporting incidents when they first started almost a year agoDuring a telephone interview on 06/09/2026 at 2:17 PM, the Director of Housekeeping stated Housekeeper #1 called them at home on [DATE] around 4:00 PM. Housekeeper #1 stated they witnessed something but did not want to say anything because they were afraid of retaliation. The Director of Housekeeping told them they needed to tell them about it. Housekeeper #1 reported they witnessed one of the aides push one of the residents down. The Director of Housekeeping stated they told Housekeeper #1 they would have to go into the facility, but they said they could not go back to the facility then but would go in the next morning. The Director of Housekeeping stated they told the Housekeeper #1 it would have to be reported within 24 hours. The Director of Housekeeping stated they did not notify the Administrator or Director of Nursing because (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Housekeeper #1 was timid and seemed confused about what they witnessed, what time it happened, and they wanted to talk to them to get the correct information. The Director of Housekeeping stated they reported this to the Director of Nursing the next morning (06/03/2026). They stated they thought it had to be reported within 24 hours but had Housekeeper #1 reported it before they left work that day (06/02/2026), it would have been reported on time. During an interview on 06/09/2026 at 3:06 PM, the Director of Nursing stated the Director of Housekeeping did not report it to the Administrator or themselves because they were not sure about the details. The Director of Nursing stated the Director of Housekeeping should have reported what Housekeeper #1 told them right away to the Administrator or themselves even if the details were unclear as it was their job to do an investigation and determine the timeframe for reporting, two hours versus 24 hours.During an interview on 06/09/2026 at 3:37 PM, the Administrator stated Housekeeper #1 might have felt intimidated/scared to report it, they called the Director of Housekeeping around 4:00 PM and told them what they saw that day. The Director of Housekeeping told them to tell administration about it in the morning. The Administrator stated the Director of Housekeeping did not report it immediately because Housekeeper #1 was not making sense, but they should have reported it right after Housekeeper #1 reported it to them. The Administrator stated they were aware of the incident around 8:30 AM the next morning (06/03/2026) and that abuse allegations were supposed to be reported no later than two hours after the allegation was made.The following corrective actions were implemented by the facility to correct the non-compliance as of 06/06/2026. -Certified Nursing Assistant #1 was removed from resident contact on 06/03/2026.-Resident #1 was assessed by nursing, medical, and social work staff and no ill effects were noted.-During the abbreviated survey completed 06/09/2026 Resident #1 had no signs of abuse observed.-Starting on 06/04/2026 all facility staff were re-educated on resident rights, abuse and abuse reporting.-During the abbreviated survey completed 06/09/2026, it was verified through staff interviews and record review that the facility had re-educated 100% of their staff on abuse which included types of abuse and abuse reporting process including timeframes.-During the abbreviated survey completed 06/09/2026, it was verified through staff interviews and record review that on 06/04/2026 incident reports were reviewed dating back to 03/02/2026 for reporting timeframes and abuse instances by the Director of Strategic Planning. Certified Nurse Aide #1's file was reviewed with no prior discipline or incidents and had the required abuse education. 10 New York Codes, Rules, and Regulations 415.4(b)(2)