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	10/10/2025

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

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 interviews and record review conducted during an Extended Recertification Survey and complaint investigations (#NY00385595 - 574018, #NY00381410 - 574678) completed on 10/10/2025, the facility failed to protect residents' right to be free from physical abuse, mistreatment, and neglect for five (5) (Residents #15, #29, #34, #91, #135) of eight (8) residents reviewed for abuse. Specifically, the facility failed to implement sufficient interventions to protect and prevent resident-to-resident abuse resulting in Resident #155 hitting four (4) residents between 02/15/2025 to 07/02/2025. Administration and medical staff failed to recognize abuse and neglect. This resulted in, or had the likelihood for, psychosocial harm and physical harm that is Immediate Jeopardy and Substandard Quality of Care for Residents #15, #29, #34, and #91 with the likelihood to affect all residents (census 145) in the facility. In addition, Certified Nurse Aide #7 used profanity and spoke to Resident #135 in a demeaning manner, then neglected to provide incontinence care and left the resident sitting in a soiled brief in their wheelchair with their pants down to their knees.The findings are:The policy titled Abuse and Neglect - Clinical Protocol with a revised date of March 2018 documented that abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Willful as defined and as used in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.The policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revised date of April 2021, documented residents had the right to be free from abuse and neglect, misappropriation of resident property and exploitation. That included but was not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, physical or chemical restraint to treat the resident's symptoms1. Resident #155 had diagnoses including frontotemporal neurocognitive disorder (brain disorder that affects personality, behavior, and language), dementia without behavioral disturbances, and adult failure to thrive. The Minimum Data Set (a resident assessment tool) dated 05/16/2025 documented Resident #155 was severely cognitively impaired, was understood, and usually understands.The Comprehensive Care Plan initiated 11/24/2024 documented Resident #155 exhibited self-directed harm or harm directed at others. Interventions included to allow resident personal space if safe wandering or pacing, initiate visual supervision during acute episode, maintain consistent schedule with daily routine, minimize environmental stimuli, monitor for signs or symptoms of agitation, provide clear simple instructions, engage in activities, offer food or snack, offer to toilet, and/or redirect as needed. On 03/30/2024, a focus was initiated that documented Resident #155 had the potential to be physically aggressive when redirected. Interventions included to adjust voice tone, approach from the front, assess and anticipate resident's needs, administer meds as ordered, analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document, provide calm environment, engage in conversation. Additionally, on 07/03/2025 an intervention to provide resident with calm environment in their room when noted behaviors of aggression/agitation arise was (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 - Immediate jeopardy to resident health or safety Residents Affected - Many	initiated. Review of the care plan revealed there were no changes made to the resident's plan of care after the 02/15/2025 or the 06/07/2025 altercations. a. Resident #91 had diagnoses including dementia with behavioral disturbances, schizoaffective disorder bipolar type (mental health disorder characterized by a persistent and significant disturbances in thought, perception, emotion, and behavior), and major depressive disorder. The Minimum Data Set, dated [DATE] documented Resident #91 was severely cognitively impaired, understands, and was understood by others.The Comprehensive Care Plan dated 03/14/2022 (current) documented Resident #91 was dependent on staff for meeting emotional, intellectual, physical, and social needs and had impaired cognitive function and/or impaired thought processes related to dementia. The Nursing Home Facility Investigation Summary dated 02/15/2025 at 2:45 PM, completed by Director of Nursing documented that Activities Aide #1 witnessed Resident #155 walk over to Resident #91 and ask for their Pepsi. Resident #91 said no and blocked Resident #155 from taking it. Resident #155 attempted to hit Resident #91 to get their attention. Resident #91 backed up and Resident #155 made contact with Resident #91's right cheek. Activities Aide #1 separated the residents. Activities Aide #1 was interviewed and stated, Resident #155 may have touched Resident #91, but it could not have been hard as it did not phase Resident #91. Resident #91 was assessed, had no bruising or discoloration, and did not recall the incident. Resident #155 was redirected and provided a drink. Both residents were placed on behavior monitoring for seventy-two (72) hours.The 24-hour Nursing Reports dated 02/15/2025 to 02/18/2025 documented Resident #155 and Resident #91 were to be monitored for behaviors. Review of the nursing reports revealed Resident #91 had incomplete documentation on 02/15/2025, from 3:00 PM through 7:00 AM on 02/16/2025, and during 3:00 PM to 11:00 PM on 02/16/2025. Resident #155 had incomplete documentation on 02/16/2025 during 7:00 AM to 11:00 PM and 02/18/2025 during 7:00 AM to 3:00 PM.b. Resident #34 had diagnoses including syncope (fainting), hypertension (high blood pressure), and cataracts (clouding of the eyes lens). The Minimum Data Set, dated [DATE] documented Resident #34 was moderately cognitively impaired, was understood, and understands others.The Comprehensive Care Plan dated 10/11/2022 (current), documented Resident #34 was independent with ambulation, was dependent on staff for meeting their emotional, intellectual, physical, and social needs, was not an independent decision maker, but was able to make their needs known.Review of the Nursing Home Facility Investigation Summary dated 03/30/2025 at 1:00 PM, completed by the Director of Nursing, documented Licensed Practical Nurse #9 heard Resident #34 yelling, and they went to their room. Resident #34 informed Licensed Practical Nurse #9 that Resident #155 walked into their room, and Resident #155 made physical contact with their hand to their face, then walked out of the room. Resident #34 was assessed and had redness noted to their face. Resident #34 stated they were not bothered by the incident. Following the incident, a stop sign was placed on Resident #34's door to prevent further unwanted guests, and both residents were placed on behavior monitoring for 72 hours. Resident #34's documented statement in the investigation documented that Resident #155 hit them.The 24-hour Nursing Reports dated 03/30/2025 to 04/03/2025, documented Resident #155 was to be monitored for behaviors. The reports were incomplete and had incomplete documentation on 03/31/2025 during the 3:00 PM to 7:00 AM shift, and on 04/01/2025 during the 3:00 PM to 11:00 PM shift. There was no documented evidence that Resident #34 was placed on the 24-hour Nursing Report for behavior monitoring from 03/30/2025 to 04/03/2025, as per the investigation summary.c. Resident #29 had diagnoses including Wernicke's encephalopathy (neurological emergency caused by the lack of thiamine (vitamin B1)/alcohol induced persisting dementia), history of trans ischemic attack (temporary interruption of blood flow to the brain, causing stroke like symptoms), and cerebral infarction (stroke). The Minimum Data Set, dated [DATE] documented Resident #29 was severely cognitively impaired, was understood, and usually understands others.The Comprehensive Care Plan dated 08/31/2023 (current), documented Resident #29 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to mild cognitive impairment. The resident was independent with (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	wheelchair mobility. On 05/22/2024 an addition to the comprehensive care plan documented Resident #29 was at risk for victimization due to being involved in a resident-to-resident altercation where they were the victim (involved a threat of being harmed by another resident with sharp scissors).Review of the Nursing Home Facility Investigation Summary dated 06/07/2025 at 12:30 PM, completed by the Director of Nursing, documented Certified Nurse Aide #13 saw Resident #29 sitting in their wheelchair outside of their room and Resident #155 was approaching Resident #29's room. Resident #29 tried to redirect Resident #155 by saying turn around and go back that way. Resident #155 threw a box of gloves they were holding at Resident #29 and hit Resident #29 in the face with the box of gloves. Resident #155 then walked up to Resident #29, and with a closed fist punched them on their left cheek. The residents were separated. Resident #29 was assessed and had no injuries, their room was moved immediately following the incident to an area closer to the nurses' station, where Resident #155 did not frequent. Resident #29 was thrilled with the room change. Resident #155 was redirected by staff to the other end of the unit and was assessed and found to have no injuries. Resident #155 was calm and redirectable.Review of 24-Hour Nursing Reports, dated 06/07/2025 to 06/10/2025, revealed there was no documented evidence that Resident #29 and Resident #155 were placed on the 24-hour Nursing Report for behavior monitoring, until 06/09/2025 at 7:00 AM.d. Resident #15 had diagnoses including dementia without behavioral disturbances, anxiety, and arthritis (joint inflammation that causes pain). The Minimum Data Set, dated [DATE] documented Resident #15 was severely cognitively impaired, was understood and understands others.The Comprehensive Care Plan dated 05/22/2025 documented Resident #15 had impaired cognitive function related to dementia and to cue, reorient and supervise as needed. Resident #15 had poor safety awareness and staff were to anticipate and meet the resident's needs.The Nursing Home Facility Investigation Summary dated 07/02/2025 at 4:40 PM completed by the Director of Nursing documented the Minimum Data Set Nurse/Nursing Supervisor #1 heard Certified Nurse Aide #9 yell, They just hit them! At that time, Resident #15 was observed ambulating down the hallway crying and holding their left cheek and head with both of their hands. Resident #155 was also observed ambulating down the hallway. Resident #15 approached the nurses' station and there was an abrasion to their left cheek measuring 2.5 centimeters with redness extending up to the temple area. Resident #15 was asked to demonstrate what had happened. They made a fist with their right hand and made a hitting motion. Resident #155 was asked to describe what happened. They closed their right hand into a fist and struck the palm of their hand twice. It was determined that Resident #155 walked up to Resident #15 and struck them in the face with their hand. Resident #15 was upset and afraid of Resident #155 at the time of the incident. Immediately after the incident, Resident #15 had a room change to the second floor. Resident #155 was monitored for changes in behavior and was placed on the 24-hour nursing report. The Resident-to-Resident Incident Report for Resident #15 dated 07/02/2025, completed by Minimum Data Set Nurse/Nursing Supervisor #1, documented that after Resident #15 was struck in the face, the resident was afraid of Resident #155. Resident #15 was taken behind the nurses' station to ensure their safety and to provide comfort. Ice was applied to Resident #15's cheek/temple area and Tylenol (pain reliever) was administered for complaints of throbbing pain to the left side of their head.Review of the Vitals and Pain Evaluations form dated 07/02/2025 at 4:55 PM, documented Resident #15 had sharp, severe (level eight (8) out of 10, non-radiating pain to their head, and was exhibiting facial expressions of discomfort. A cool compress was applied, and Resident #15 received as needed pain medication.The 24-hour Nursing Report dated 07/02/2025 to 07/05/2025 revealed behavior next to Resident #155's name. There was no evidence of behaviors being monitored and documented throughout the day (7:00 AM to 7:00 PM). The 24-hour Nursing Report dated 07/03/2025 revealed Resident #155 was being monitored for behavior on one (1) day (07/03/2025 3:00 PM to 11:00 PM) out of 35 days.There is no documented evidence interventions put in place for Resident #155 were evaluated for effectiveness or to assure the safety of residents following each incident.Review of a progress note dated 07/08/2025 revealed Nurse Practitioner #2 documented that Resident #155 was (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	seen for follow up after a resident-to-resident negative altercation where Resident #155 was the aggressor. Both residents were separated. Resident #155 is managed on Depakote (mood stabilizer) and Lexapro (medication used to treat depression and anxiety). The note documented to follow up with psych services as indicated.Review of a psychiatric consult note dated 09/18/2025 revealed Psychiatric Nurse Practitioner #1 documented that Resident #155 was seen for a psychiatric follow up visit. Staff and the Health Care Proxy (agent, person to make health care decisions) stated that Resident #155 had no recent physical aggression or behavioral disturbances on the unit. The Health Care Proxy Agent stated that Resident #155 made rash decisions. Based on observations, it was determined Resident #155 was alert, minimally verbal, and impulsive. Based on patient evaluation, symptoms, staff reports and collaboration, recent medical chart history reviewed, and current medications were reviewed. Psychiatric Nurse Practitioner #1 recommended no new medication changes; to provide non-pharmacological interventions; continue to monitor for changes in mood and behavior; and to monitor psychiatric changes. Behavioral symptoms are being actively monitored and continue to provide non-pharmacological interventions and monitor for changes in mood and behavior.During an interview on 09/11/2025 at 10:28 AM, the Director of Strategic Planning stated there were no behavior monitoring sheets for Resident #155, only what was documented on the 24-hour Nursing Reports.During an interview on 09/11/2025 at 12:54 PM, Minimum Data Set Nurse/Nursing Supervisor #1 stated Resident #155 was impulsive and did not understand the consequences of their actions. Minimum Data Set Nurse/Nursing Supervisor #1 stated Resident #15 was moved to another floor, but they could not recall any specific interventions put into place to keep other residents safe from Resident #155 following the incident on 07/02/2025.During an interview on 09/11/2025 at 3:18 PM, Certified Nurse Aide #9 stated on 07/02/2025 after the incident, Resident #15 was upset, in pain, and stated Resident #15 was afraid of Resident #155. They took Resident #15 to the nurses' station, and they immediately told Minimum Data Set Nurse/Nursing Supervisor #1 because they felt Resident #155 physically abused Resident #15.During a telephone interview on 09/12/2025 at 9:56 AM, Certified Nurse Aide #3 stated they were Resident #155's assigned aide on 07/02/2025 from 3:00 PM to 11:00 PM, and they were not told to increase their monitoring of Resident #155 following the incident.During a telephone interview on 09/12/2025 at 10:05 AM, Licensed Practical Nurse #5 stated they were Resident #155's assigned nurse 3:00 PM to 11:00 PM on 07/02/2025 and were not told to increase the monitoring of Resident #155. Licensed Practical Nurse #5 stated if they did do any increased monitoring, it would have been documented in the nursing progress notes or on the 24-hour Nursing Report. They added, if it was not documented, then the increased monitoring did not occur.During an interview on 09/15/2025 at 9:48 AM, the Director of Social Work stated they were informed of the incident between Resident #15 and Resident #155 the next day. They interviewed both residents and stated neither resident recalled the incident. The Director of Social Work stated the incident was abuse because Resident #155 caused physical harm to Resident #15. During an interview on 09/15/2025 at 10:46 AM, the Director of Nursing stated Resident #155 did not like other people in their personal space, so they assumed Resident #15 got into Resident #155's personal space causing Resident #155 to react. The Director of Nursing stated following the incident, Resident #15 was moved to a different floor, and behavior monitoring was started for Resident #155, which should have been documented on the 24-hour Nursing Report. The Director of Nursing stated the incident on 07/02/2025 was resident-to-resident physical abuse that caused harm to Resident #15. During a telephone interview on 09/15/2025 at 11:34 AM, Nurse Practitioner #1 stated following the incident, they evaluated both residents and neither resident was cognitively intact. They stated it was a situational reaction and stated they did not feel abuse occurred between the residents, but Resident #155 had caused harm to Resident #15. Nurse Practitioner #1 stated they would have expected an immediate intervention to have been put into place to keep all other residents on the fourth floor safe. During a telephone interview on 10/08/2025 at 1:11 PM, Psychiatric Nurse Practitioner #1 stated they were asked to see Resident #155 due to (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	their diagnoses. When they approached the unit, they started talking to staff who do direct care and they explained Resident #155's behaviors. They stated they also had a conversation with Resident #155's Health Care Proxy Agent. Psychiatric Nurse Practitioner #1 stated Resident #155 was intrusive because while they were talking to Resident #155's Health Care Proxy Agent, Resident #155 came up to them (Psychiatric Nurse Practitioner #1) and almost kissed them on the lips. Resident #155's Health Care Proxy Agent stated Resident #155 was only aggressive if someone got in their personal space. Psychiatric Nurse Practitioner #1 stated they reviewed Resident #155's progress notes and saw that they hit someone and was under the assumption this other person got into Resident #155's personal space causing Resident #155 to react. They also stated they were unaware of any other incidents involving Resident #155. Psychiatric Nurse Practitioner #1 stated they were unsure of what Resident #155's triggers were. They stated they had spoken with Director of Nursing on 09/18/2025 and educated them that an in-service on de-escalation would be beneficial for facility staff, and education was needed on Resident #155s ? triggers and how to approach them. Due to their condition, Resident #155 was impulsive, and may get agitated and strike out. Additionally, Psychiatric Nurse Practitioner #1 stated they informed the Director of Nursing they needed to have something in Resident #155's plan of care related to de-escalation techniques, have them more involved and keep them busy. Psychiatric Nurse Practitioner #1 stated these incidents were humiliating, and degrading for all residents involved. The resident-to-resident incident between Resident #15 and Resident #155 on 07/02/2025 was harm.During a telephone interview on 10/08/2025 at 1:40 PM, Nurse Practitioner #2 stated they saw Resident #155 following the incident on 07/02/2025 and referred them to see psych because the resident had been recommended for an increase in their Depakote. Nurse Practitioner #2 stated they did not feel the incident on 07/02/2025 between Resident #15 and Resident #155 was abuse, because Resident #155 did not have the cognitive ability to do it. Nurse Practitioner #2 stated they were unaware of Resident #155's previous incidents, but there were other providers who worked with Resident #155 as well. Nurse Practitioner #2 stated they would have expected the psych consult to have been scheduled in a timely manner and July to September was not timely. During a telephone interview on 10/08/2025 at 2:23 PM, the Medical Director stated they were informed that Resident #155 punched Resident #15 because Resident #15 got into Resident #155's space and Resident #155 was trying to defend themselves. It was just two demented patients fighting. The Medical Director stated, they did not feel as though the incident was abuse, or any of the incidents with Resident #155, because they have dementia, and you cannot really control what people with dementia will do. The Medical Director stated there should have been monitoring of all residents involved following the incidents. A reasonable person would not be accepting of being punched in the face. That population is going to hit each other and sometimes that is just how it is going to be. The Medical Director stated they did not feel as though there was harm when Resident #155 punched Resident #15. Someone could be hurt, but that does not mean there was harm.During an interview on 10/08/2025 at 3:07 PM, the Director of Nursing, with the Director of Strategic Planning present, stated they felt all interventions put into place following each incident involving Resident #155 (02/15/2025, 03/30/2025, 06/07/2025, and 07/02/2025) were appropriate interventions. Resident #155 had a Depakote increase on 07/24/2025 and had no behaviors against other residents since then. The Director of Nursing stated they were planning on talking about some de-escalation techniques but had not yet met again with Psychiatric Nurse Practitioner #1.During an interview on 10/09/2025 at 11:14 AM, the Director of Strategic Planning stated they felt all their interventions were appropriate that were put into place after each incident involving Resident #155. The Director of Strategic Planning stated they would have expected Nurse Practitioner #2 to have been aware of all Resident #155's incidents. The Director of Strategic Planning stated if there was an order or recommendation made by a provider, they would have expected the unit manager to follow through with the recommendation. A recommendation made in July should have been carried out before September as there was a brief lapse in psychiatric providers in facility. The Director of Strategic (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	pants down by their knees. The resident did not have a blanket over their lap, and they were unable to pull their pants up independently. They took the resident's statement and reported the incident to the Director of Nursing. The Director of Social Work stated the incident could be abuse, but the resident did not express that they were harmed.During an interview on 09/15/2025 at 11:05 AM, Resident #135 stated they recalled the incident with Certified Nurse Aide #7. They stated Certified Nurse Aide #7 was very rude at breakfast and used foul, profane language. Then they did not want to get them up for therapy, so they hurried them up into their chair and left them dirty with their pants halfway down. The resident stated they did not feel they were abused but felt undignified.During an interview on 09/15/2025 at 11:14 AM, Licensed Practical Nurse #4 stated they entered Resident #135's room shortly after breakfast and the resident had reported to them Certified Nurse Aide #7 had been rude. About an hour later, they observed Resident #135 wheeling back from the therapy room with their pants down by their knees. Physical Therapist #1 stated to them they had already notified Social Work. Licensed Practical Nurse #4 stated the incident was a form of abuse.During an interview on 09/15/2025 at 11:34 AM, Physical Therapist #1 stated Resident #135 was in their wheelchair with their pants down by their knees. They asked the resident why their pants were down, and the resident responded the aide did not want to do it and never came back. Physical Therapist #1 stated Resident #135 was very upset and emotional about the situation. Physical Therapist #1 stated the incident was abuse and a violation of the resident's right to dignity.During an interview on 09/15/2025 at 11:40 AM, Registered Nurse #4 stated they recalled there was an incident with Certified Nurse Aide #7, and they sent the aide home. Registered Nurse #4 stated the incident was abuse and a violation of Resident #135's right to dignity.During an interview on 09/16/2025 at 9:18 AM, Director of Nursing stated they ruled out abuse because Resident #135 stated they were happy with their care, and they were not psychologically harmed or upset by the incident. They stated it could be an issue with dignity, but Resident #135 did not express to them that they were very upset about it.During an interview on 09/16/2025 at 9:52 AM, the Administrator stated they ruled out abuse because it was determined that there was no physical or psychological harm to Resident #135.During a telephone interview on 10/09/2025 at 1:11 PM, Psychiatric Mental Health Nurse Practitioner stated they did not feel as though Resident #135 experienced any psychosocial harm from the incident as the resident was happy after the incident knowing Certified Nurse [NAME] #7 was removed from their care. During an interview on 10/08/2025 at 3:07 PM, the Director of Nursing stated they did not feel that the incident was neglect, and they only sent it in to the Department of Health because they wanted to fire the accused Certified Nurse Aide or else we wouldn't have reported it as they did not feel it was any kind of abuse. 10NYCRR 415.4(b)(1)(i)

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	335164	A. Building B. Wing	10/10/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 interviews and record review conducted during Complaint investigations (#NY00365084-574660, #NY00385595-574018, NY00381410- 574678) completed during an Extended recertification survey completed on 10/10/2025, the facility did not ensure that all alleged violations involving abuse, neglect, mistreatment, including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for five (5) (Resident #8, #15, #131, #135 and #155) of five (5) residents reviewed. Specifically, the results of an abuse allegation investigation were not sent to the State Agency within five (5) working days of the incident (Residents #15, #135 and #155). Additionally, an allegation of abuse was not reported to the State Agency within the 2-hour required time frame (Residents #8, #131, and #135). This resulted in no actual harm with the potential to affect all residents that is substandard quality of care.The findings are:The policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised April 2021 documented if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law. Immediately is defined as: within two (2) hours of an allegation involving abuse or result in serious bodily injury. The administrator, or his/her designee, provide the appropriate agencies or individuals listed with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. 1. Resident #15 had diagnoses including dementia without behavioral disturbances, anxiety disorder, and arthritis (joint inflammation that causes pain). The Minimum Data Set (a resident assessment tool) dated 05/29/2025 documented Resident #15 was severely cognitively impaired, was understood and understands. Resident #155 had diagnoses including frontotemporal neurocognitive disorder (brain disorder that affects personality, behavior, and language), dementia without behavioral disturbances, and adult failure to thrive. The Minimum Data Set, dated [DATE] documented Resident #155 was severely cognitively impaired, was understood, and usually understands.The nursing home facility investigation report submitted successfully to the State Agency completed by the Administrator documented an allegation of physical abuse had occurred at 4:40 PM on 07/02/2025. The Administrator was first made aware on 07/02/2025 at 4:47 PM. The incident was submitted to the State Agency on 07/02/2025 at 6:08 PM. There was no documented evidence that the full/results of the abuse investigation was sent to the State Agency within five (5) working business days.The undated facility Investigation Summary documented the date and time of the event was 07/02/2025 at 4:40 PM, and time Director of Nursing #2 notified was 07/02/2025 at 4:45 PM. The Investigation Summary documented Certified Nurse Aide #9 heard a loud thud and saw Resident #15 walking away from Resident #155, holding their left cheek with both hands, visibly upset and fearful of Resident #155. Minimum Data Set Nurse/Nursing Supervisor #1 heard Certified Nurse Aide #9 yell they just hit them, and saw Resident #15 ambulating down the hallway coming from the main dining room with a quick steady pace approaching the nurses station crying and holding both of their hands up to their left cheek/side of their head, a 2.5 centimeter abrasion with redness and swelling extending up to their temple was noted. Minimum Data Set Nurse/Nursing Supervisor #1 immediately notified Director of Nursing #1, and the incident was reported to the New York State Department of Health on 07/02/2025 at 6:08 PM.During an interview on 09/15/2025 at 10:46 AM, Director of Nursing #1 stated they completed the investigation, but Director of Nursing #3 was responsible for sending the information into the New York State Department of Health for review, and they did not know why it (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was never sent. Director of Nursing #1 stated it was regulation to send in the investigation within five (5) working business days after the initial submission, and the investigation should have been submitted.During a telephone interview on 09/15/2025 at 11:54 AM, Director of Nursing #3 stated they were made aware of the incident on 07/02/2025 and immediately made the Administrator aware so the investigation could begin. Director of Nursing #3 stated they obtained witness statement and gave them to Director of Nursing #1 who they thought submitted the five-day investigation information.During an interview on 09/15/2025 at 2:25 PM, the Administrator stated if Director of Nursing #1 or Director of Nursing #3 failed to submit the full investigation, the Administrator was ultimately responsible for ensuring that the full investigation was successfully uploaded and sent to the State Agency within five business days. The Administrator stated they typically would receive a call asking about the investigation but had not; so, it got away from them; the full investigation should have been submitted within five working business days.During a follow up interview on 09/16/2025 at 9:32 AM, Director of Nursing #1 stated ultimately the Administrator was responsible for ensuring the full investigation was sent into the State Agency within five working business days, and it was not.2. Resident #135 had diagnoses including hypertension (high blood pressure), deep vein thrombosis (blood clot in the vein) of the right lower extremity, and anemia (not enough red blood cells to carry oxygen throughout the body). The Minimum Data Set, dated [DATE], documented they were always understood and always understands others, and they were moderately cognitively impaired. The comprehensive care plan, initiated 03/06/2025, documented Resident #135 had an Activities of Daily Living self-care performance deficit. They required extensive assistance from one (1) staff for dressing and toileting and required setup for eating. Resident #135 was occasionally incontinent and wore a brief.Review of the New York State Department of Health Complaint Tracking System Complaint/Incident Investigation Report revealed the date/time of the alleged incident was 05/20/2025 at 11:00 AM. The date/time the Administrator was first made aware of the incident was 05/20/2025 at 3:45 PM. It was submitted by the facility to the New York State Department of Health on 05/21/2025 at 8:23 PM. Review of the Nursing Home Investigative Report revealed the facility submitted their investigation results on 05/28/2025 at 12:56 PM. There was no documented evidence that the results of the abuse investigation were sent to the State Agency within five (5) working business days.The facility incident report Verbal Aggression Received, prepared by Director of Nursing #1, dated 05/20/2025 at 1:00PM, documented Resident #135 stated when they requested Certified Nurse Aide #7 to cut their pancakes, and then complained they were cold, Certified Nurse Aide #7 used profanity and told them they didn't care if they ate it or not. When they requested to get out of bed, changed and dressed for therapy, Certified Nurse Aide #7 told them they would not be getting them up. Certified Nurse Aide #7 did return, got them out of bed to their wheelchair, did not change their brief and left their pants only pulled up to their mid-thigh, unbuttoned and unzipped.The Investigation Summary/QA Privilege report dated 05/29/2025, completed by Director of Nursing #1, documented it was determined the incident was not abuse because Resident #135 did not suffer physical or psychological harm.During an interview on 09/15/2025 at 10:07 AM, the Director of Social Work stated on 05/20/2025 they were called by Physical Therapist #1 to come see Resident #135 in therapy. Resident #135 was in their wheelchair, in a soiled brief with their pants down by their knees. They were unable to pull them up themselves. They did not have a blanket over their lap. They took their statement and reported the incident to the Director of Nursing.During an interview on 09/15/2025 at 11:05 AM, Resident #135 stated they recalled the incident with Certified Nurse Aide #7. They stated Certified Nurse Aide #7 was very rude at breakfast and used foul language. Then they didn't want to get them up for therapy, so they hurried them up into their chair and left them dirty with their pants halfway down. Resident #135 stated they shouldn't be treated that way and it made them feel terrible to be left that way when they were not strong enough to lift their butt up to pull up their pants.During an interview on 09/15/2025 at 11:34 AM, Physical Therapist #1 stated they saw Resident #135 in their wheelchair with their pants down by their knees. Physical Therapist #1 stated (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #135 was very upset and emotional about the situation. They immediately notified the Director of Social Work, their manager and Registered Nurse #4. Physical Therapist #1 stated Resident #135 expressed gratitude for sitting with them and actually caring about what happened. Physical Therapist #1 stated the incident was abuse and a violation of the resident's right to dignity.During an interview on 09/16/2025 at 9:18 AM, Director of Nursing #1 stated they spoke with Resident #135 on 05/20/2025 and they ruled out abuse because the resident did not appear psychologically harmed by the incident. Director of Nursing #1 stated the incident was reported to the New York State Department of Health on 05/21/2025 around 8:00 PM. They stated the incident did not need to be reported within two (2) hours because the resident was not physically or psychologically harmed. Director of Nursing #1 stated the incident should have been reported within 24 hours.During an interview on 09/16/2025 at 9:52 AM, The Administrator stated they were notified of the incident on 5/20/2025 around 3:35 PM. They stated they ruled out abuse because nursing staff assessed the resident and determined no physical or psychological harm occurred. They stated if there was no injury or harm, the incident did not need to be reported.3. Resident #8 had diagnoses including Parkinson's Disease (tremors and rigidity of movement), dementia, and schizophrenia. The Minimum Data Set, dated [DATE] documented Resident #8 had moderate cognitive impairment.Resident #131 had diagnoses including dementia, cerebral infarction (stroke), and anxiety. The Minimum Data Set, dated [DATE] documented Resident #131 had severe cognitive impairment.The nursing home facility investigation report submitted successfully to the State Agency completed by Director of Nursing #2 documented an allegation of sexual abuse had occurred on 12/15/2024 at 6:51 PM. The Administrator was first made aware on 12/15/2024 at 6:53 PM. The incident was submitted to the State Agency on 12/16/2024 at 3:01 PM. The undated facility Investigation Summary documented the date and time of the event was 12/15/2024 at 6:51 PM, and Director of Nursing #2 notified was 12/15/2024 at 6:53 PM. The Investigation Summary documented Certified Nurse Aide #10 discovered Resident #8 in their wheelchair next to Resident #131's bed. Registered Nurse Supervisor #2 was immediately notified. The Investigation Summary documented the incident was reported to the New York State Department of Health on 12/16/2024 at 3:01 PM.During an interview on 9/12/2025 at 8:33 AM, Licensed Practical Nurse #3 stated abuse was to be reported to the unit manager or nursing supervisor right away. The abuse then needed to be reported to the New York State Department of Health within two (2) hours. During a telephone interview on 9/12/2025 at 8:55 AM, Registered Nurse Supervisor #2 stated they did not recall the whole situation that had occurred, but remembered it seemed suspicious for abuse and was something that needed to be investigated. They could not recall if they notified Director of Nursing #2 or the Administrator, but they notified them immediately because that was what they were required to do for anything that had the potential to be sexual abuse. They stated they did not know the time frame for the incident to be reported to the New York State Department of Health and that was the Director of Nursing or Administrator's responsibility. A telephone call was made on 9/12/2025 at 9:13 AM and on 9/15/2025 at 10:13 AM to Director of Nursing #2. They did not return the phone call. During an interview on 9/12/2025 at 11:18 AM, Registered Nurse #1 Resident Care Coordinator stated abuse needed to be immediately reported to the nursing supervisor, Director of Nursing and/or the Administrator. They were required to report abuse to the New York State Department of Health within two (2) hours because any allegations needed to be addressed quickly. They stated abuse needed to be addressed quickly because if it was not, then statements might not be as accurate as time went on. Registered Nurse #1 Resident Care Coordinator stated they remembered parts of the investigation for the incident between Resident #8 and Resident #131. They recalled therapy completing a reenactment with Resident #8 and that was how abuse was ruled out, but they were not sure when the incident was reported to the New York State Department of Health. During an interview on 9/15/2025 at 12:52 PM, Director of Nursing #1 stated Director of Nursing #2 was responsible for reporting the incident between Resident #8 and Resident #131 to the New York State Department of Health. They stated, according to the Investigation Summary, Registered Nurse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Supervisor #2 had notified Director of Nursing #2 on 12/15/2024 at 6:53 PM and Director of Nursing #2 reported the incident to the New York State Department of Health on 12/16/2024 at 3:01 PM. Director of Nursing #1 stated the investigation was to rule out sexual abuse and that should have been reported to the New York State Department of Health within two (2) hours. They stated they did not know the reason why Director of Nursing #2 did not report the incident in a timely matter. During an interview on 9/15/2025 at 1:10 PM the Administrator stated they could not remember the details of the incident between Resident #8 and Resident #131 but based on the initial report that was submitted to the New York State Department of Health, there was potential for sexual abuse, and it was reported to administration within two (2) hours. They stated the report was submitted by Director of Nursing #2 on 12/16/2024 at 3:01 PM. The Administrator stated the incident was not reported correctly. Both the Director of Nursing and Administrator of the facility were responsible for reporting incidents to the New York State Department of Health. The Administrator stated ultimately, they were responsible for overseeing that the Director of Nursing had reported the incident timely. They stated it should have been reported timely because there could have been sexual abuse or an injury that had occurred however, their investigation showed that abuse did not occur. 10 NYCRR 415.4(b)(2)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review conducted during a Complaint investigation (NY00372414 - 574672) during the Standard survey completed on 09/19/2025, the facility did not ensure that there was sufficient nursing staff with the appropriate competencies on a 24-hour basis to attain or maintain the highest practicable physical, mental and psychosocial well-being for residents in the facility (floors two (2), three (3), four (4)). Specifically, there was insufficient staff to meet all the residents needs including long wait times to get mediations and call bells answered, toileting/hygiene, and showers. Additionally, the facility did not meet their assessed minimum staffing levels for Licensed Nurses based on the facilities assessment to meet the needs of each resident. The findings are:The undated Facility Assessment documented registered nurse numbers were based on census and licensed practical nurse numbers would be based on census/acuity and level of care. The assessment documented that the staffing and competencies section provided an evaluation of the overall number and types of staff needed to provide the level and types of care appropriate for the resident population. It was a competency-based approach to determine the knowledge and skill required to ensure residents were able to monitor or attain the highest practicable physical, functional, mental and psychosocial well-being and meet current professional standards of practice. An addendum to the Facility Assessment documented the facility staffing was census and acuity based would fluctuate based on admissions/discharge. The addendum documented for a census of 149 the minimums would be one licensed practical nurse per unit per shift with a registered nurse on call. a. Review of the Resident Council Minutes Summary dated 07/25/2025 documented the residents state certified nurse assistants (especially on the night shift) were slow to answer call bells and all nursing staff needed to pitch in to attend to call bells in as timely a fashion as possible. Review of the Resident Council Minutes Summary dated 08/29/2025 documented call bells need to be responded to in a timelier manner and all nursing staff should attend to call bells as quickly as possible. During an interview on 09/09/2025 at 12:41 PM, Resident #114 stated they cannot move by themselves in bed and there have been times when they have waited over two (2) hours to have incontinent care completed, leaving them in a soaking wet brief. Resident #114 stated they push the call light, but no one pays attention, every shift is the same. Staff will come into the room, turn the light off then never return. Nurses were overwhelmed with work. During an interview on 09/09/2025 at 1:03 PM, Resident #75 stated there have been multiple times on the overnight shift (11:00 PM to 7:00 AM) that they would ring their bell because they were in pain and needed their pain medication. No one answered for hours. Resident #57 stated one time they got up after ringing for over an hour to look for staff on the second floor around 3:00 AM. They stated they could not locate any staff on the floor and they had waited over three hours for their pain medication that night. During an interview on 09/10/2025 at 9:32 AM, Resident #5 stated they have not had a shower in three weeks. They stated the certified nurse aides tell them they do not have enough staff to give them. During an interview on 09/10/2025 at 10:33 AM, Resident #114 stated the staff just walk by the room and turn the call lights off, sometimes they must wait over an hour for anyone to return because the nurses and aides are both shorthanded. During an interview on 09/10/2025 at 12:06 PM, Resident #6 stated the third shift had the worst staffing and there were not enough aides. They stated it takes a long time for the call lights to be answered. b. Resident #155 had diagnoses that included dementia, hypothyroid, and hypertension. The Minimum Data Set (a resident assessment tool) dated 08/15/2025 documented the resident have severe cognitive impairment, was usually understood and usually understands. Review of medication administration record dated 09/16/2025 documented Resident #155 was to receive levothyroxine (medication used to treat hypothyroid disease) 50 micrograms daily at 4:00 AM. The medication was not signed off as administered on 09/02/2025. During a telephone interview on 9/15/2025 at 10:42 AM, Registered Nurse #3 stated they did the best they could and prioritized the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	nursing duties on all three floors. They stated the residents got everything they needed except they could not get to Resident #155's 4:00 AM medications on 09/02/2025. During a telephone interview on 09/15/2025 at 12:03 PM, Nurse Practitioner #2 stated they stated they were not notified that Resident #155's levothyroxine dose was not given and would expect a medical provider to notified. During an interview on 09/15/2025 at 2:24 PM, the Director of Nursing #1 reviewed Resident #155's medication administration record and stated Resident #155's 4:00 AM levothyroxine was not signed as given on 09/02/2025. They stated they do not know why however cannot say it was due to staffing. Director of Nursing #1 stated the staffing numbers were not unsafe but not optimal. c. Review of the nursing staff schedule dated 09/01/2025 documented the 11:00 PM - 7:00 AM had Registered Nurse #3 listed. There was no further nursing staff listed for that shift. It was documented the census number in the facility was documented as 149. Review of nursing staff schedule dated 09/07/2025 documented the 11:00 PM - 7:00 AM had Registered Nurse #3 and Licensed Practical Nurse #2. No further nurse staff were listed for that shift. It was documented the census number in the facility was 147. During an interview on 09/15/2025 at 8:22 AM, the Staffing Coordinator stated the biggest challenge with staffing was call-offs. The Staffing Coordinator stated the minimum nurse staffing was one nurse for each floor (three floors) for all shifts and at least two certified nurse aides per floor. After reviewing the 11:00 PM-7:00 AM nursing schedules for 09/01/2025 into 09/02/2025, the Staffing Coordinator stated there was only nurse that worked in the building that shift, and it was the nursing supervisor (Registered Nurse #3). After reviewing the 11:00 PM-7:00 AM nursing schedules on 09/07/2025 into 09/08/2025, the Staffing Coordinator stated there were only two nurses in the facility working, Registered Nurse #1 and Licensed Practical Nurse #2. They stated Director of Nursing #1 was the registered nurse on-call for both days. The Staffing Coordinator stated they were not aware the facility worked with only one nurse on 09/01/2025 and two nurses on 09/07/2025 until the following mornings when they came into work. During an interview on 09/15/2025 at 8:32 AM, Director of Nursing #1 stated they were not aware of the nurse staffing numbers until 09/08/2025. Registered Nurse #3 had never called them either night (9/1-9/2 and 9/7-9/8). Director of Nursing #1 stated the facilities minimum number of nurses that should be working the 11:00 PM-7:00 AM shift would be three (3) including the nursing supervisor taking a medication cart if needed. They stated one nurse or two nurse working in the facility on the overnight shift with a census of 149 residents was not recommended. During a telephone interview on 9/15/2025 at 8:42 AM, Licensed Practical Nurse #2 stated they worked the 11:00 PM - 7:00 AM shift on 09/07/2025-09/08/2025. They stated they only worked on the second floor and was unsure what nurse staffing was available in the rest of the building. Licensed Practical Nurse #2 stated needed to contact the nursing supervisor that night as a resident was having a seizure and was sent to the hospital. During a telephone interview on 9/15/2025 at 10:42 AM, Registered Nurse #3 stated they were the 11:00 PM - 7:00 AM shift Nursing Supervisor. On 09/01/2025 they were the only nurse in the facility and on 09/07/2025 they worked with only one other Licensed Practical Nurse in the building. Registered Nurse #3 stated they had called the Staffing Coordinator, the Minimum Data Set Coordinator and other staff nurses to notify them about the need for additional nurses without success. They stated the Staffing Coordinator did return their call in the middle of the night but could not get staff to come in. Registered Nurse #3 stated one (1) to two (2) nurses on the 11:00 PM- 7:00 AM shift was not appropriate and probably not a safe situation. During a telephone interview on 09/15/2025 at 12:03 PM, Nurse Practitioner #2 stated they feel nurse staffing for the night shift would be more appropriate at three nurses in the facility to adequately complete the medication pass on each unit. During an interview on 09/15/2025 at 2:32 PM, the Administrator stated that minimum nurse staff number would be to have one nurse each shift per floor. They stated this number would also include the nursing supervisor having to take a floor as a floor nurse if they needed to. The Administrator stated the facility did fall below that number on 09/01/2025 and 09/07/2025 for the 11:00 PM-7:00 AM shift. They stated they were not aware the facility was below their minimum and the nursing supervisor did not contact them on those (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	days. The Administrator stated it was not ideal to work with one or two nurses for the overnight shift but there always was a potential for a negative outcome in the facility whether it was fully staff or understaffed. 10NYCRR 415.13(a)(b) (1) (i)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review conducted during the Extended Recertification Survey completed on 10/10/2025, the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Specifically, the administration did not ensure that psychiatric services were available, make outside arrangements or assist residents with accessing such services.The findings are:The undated Facility Assessment documented the workforce profile would list all personnel, including manager, staff (both employees and those who provide service under contract), and volunteers. The workforce profile listed that mental/Behavioral health providers would be contracted by the ((name of company) behavioral health services). Section III, Resources Needed, of the facility assessment documented the section provides an evaluation of the overall number and types of staff needed to provide the level and types of care appropriate for the resident population. It was a competency-based approach to determine the knowledge and skill required to ensure residents were able to monitor or attain the highest practicable physical, functional, mental and psychosocial well-being and meet current professional standards of practice.Review of a Job Description: Administrator revised 04/23/2012, documented under the direction of the Regional [NAME] President, the Administrator lead and directed the overall operation of the facility in accordance with resident needs, government regulations and company policies to maintain quality care for the residents while achieving the facilities business objectives. Administrative Responsibilities consisted of but not limited to working with facility management staff and consultants in planning all aspects of facility's operations, including priorities and job assignments; Ensures consultants and other support resources are appropriately utilized and a high level of inter-disciplinary teamwork is maintained.For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F 600 - Free from Abuse, Neglect and Exploitation.For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F742 - Treatment/Services for Mental/Psychosocial ConcernsResident #6 was not receiving psychotherapy services and/or group therapy services as recommended by their psychiatry provider and there was a delay in obtaining a follow up psychiatry consult as recommended for Resident #155.a. During an interview on 09/15/25 at 9:29 AM, Social Worker #1 stated the social workers were responsible for the referral process for when a resident had a recommendation to see the psychiatrist and/or psychologist at the facility. Social Worker #1 stated Resident #6 was under the psychiatric care but was not following with a psychologist. Social Worker #1 stated they did not put in a referral request for Resident #6 to have psychotherapy but should have because it was a recommendation made by the psychiatrist. They stated the previous social worker should have also put in a referral. During a telephone interview on 09/12/2025 at 11:34 AM, Psychiatrist #1stated they made a recommendation for Resident #6 to receive psychotherapy services. They stated they would have expected the social worker to follow up with the recommendations and make an appointment for counseling or even group therapy sessions. During an interview on 09/16/2025 at 9:46 AM, Director of Nursing #1 stated Resident #6 was not participating in psychotherapy with the facility's psychologist. Director of Nursing #1 stated the facility did not and could not provide a phone number for Licensed Psychologist #1 and only communicated with Licensed Psychologist #1 via email. They stated the social workers were responsible for placing any referrals for psychiatry and/or psychotherapy needs. During an interview on 09/16/2025 at 12:16 PM, Director of Nursing #1 stated they could not locate any policies on psychology consultants.b. Review of nursing progress notes dated 02/20/2025 to 09/11/2025 revealed Resident #155 was aggressive and had behaviors at times directed towards staff and other residents, had elopement attempts, wandered (continued on next page)

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Humboldt House Rehabilitation and Nursing Center	64 Hager Street Buffalo, NY 14208

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the unit and frequently entered other residents' rooms.Review of an untitled facility document dated 07/08/2025, Nurse Practitioner #2 documented Resident #155 was seen for follow up after a resident-to-resident negative altercation where they were the aggressor. Resident #155 was managed on Depakote (mediation used to treat seizures) and Lexapro (antidepressant). Nurse Practitioner #1 documented for Resident #155 to follow up with psych services as indicated.Review of Psychiatry progress note dated 09/18/2025 at 4:26 AM (late entry note), Psychiatric Nurse Practitioner #1 documented Resident #155 was seen for psychiatric follow up to monitor and assess medications. No new medication recommendations were made, and non-pharmacological interventions were encouraged.During an interview on 10/09/2025 at 11:14 AM, the Director of Strategic Planning stated there was a time gap; about a month where the facility was between psychiatric providers. They stated July to September was not an appropriate time frame for Resident #155 to have waited for a psychiatric consult after it was recommended by Nurse Practitioner #2. Director of Strategic Planning stated if there was a psychiatry recommendation made by a provider, then the facility was responsible for ensuring the recommendation was followed through. If there was not a psychiatrist available in the facility when the recommendation was made, the physician should have been notified and asked them what they wanted to do. Director of Strategic Planning stated the facility did not like to send residents out for outside psych services unless it was urgent, or the resident was dangerous. Additionally, the Director of Strategic Planning stated the social workers were previously in charge of setting up all psych consults for residents in the facility.During an interview on 10/09/2025 at 12:27 PM, the Administrator stated there was a lapse at the facility when there was no psychiatric provider. The issue with Resident #155 not seeing a psychiatric provider when it was recommended in July of 2025 fell into that time frame. The Administrator stated they should have looked at other resources for Resident #155 and any other residents who may have needed psychiatric services during that time and made an appointment.10NYCRR 415.26

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on interviews and record review conducted during the Extended Survey completed on 10/10/2025, the facility did not ensure that the Medical Director was responsible for implementing resident care policies and coordination of medical care in the facility. Specifically, the Medical Director normalized physical altercations between dementia residents. The finding is:Refer to F 600 Free from Abuse and Neglect - Scope and Severity = L The undated facility document titled Medical Director Job Description documented the Medical Director must ensure the implementation of resident care policies and coordination of medical care in the facility to promote quality, safety, and compliance with federal and state regulations. Responsibilities included but were not limited to promoting a culture of accountability, safety, and continuous improvement; provides guidance, consultation, and oversight to clinical staff as needed; promotes ethical medical practice and adherence to residents' rights and choices; ensures resident care decisions respect autonomy, dignity, and rights; and advocates for safe, compassionate, and individualized medical care.The undated policy titled Medical Director documented the Medical Director's responsibilities required that they be knowledgeable about current professional standards of practice in caring for long-term residents and about how to coordinate and oversee other practitioners; administrative decisions including recommending, developing and approving facility policies related to resident care- resident care included resident's physical, mental and psychosocial well-being; ensuring the appropriateness and quality of medical care and medically related care. The facility shall ensure all responsibilities of the medical director are effectively performed, regardless of how the task is accomplished or the technology used, to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being.During a telephone interview on 10/08/2025 at 2:23 PM, the Medical Director stated they were informed of an incident involving two residents on the dementia unit where one resident (Resident #155) punched the other resident (Resident #15) in the face causing an abrasion on residents (Resident #15) left cheek; resident (Resident #15) exhibited pain and crying, and verbalized fear of the aggressor. The Medical Director stated it was not abuse, it was just two demented residents fighting; the residents had dementia, and you cannot control what people with dementia do. The Medical Director stated a reasonable person would not be accepting of being punched in the face, but with a dementia diagnosis could not say if the resident minded or not. That population is going to hit each other sometimes, that is just how it is going to be, they hit each other. During an interview on 10/10/2025 at 10:58 AM, the Administrator stated they expected for the Medical Director to fulfill what was outlined in their duties and responsibilities; being a medical doctor, to understand the diagnosis of dementia and what comes along with residents who have dementia. The Administrator was informed of what the medical director stated regarding dementia residents and stated they would have to talk to the medical director to have a better understanding of the context of why they said what they said to make a better determination as to what they meant by it.During an interview on 10/10/2025 at 11:04 AM, the Director of Strategic Planning stated they expected the medical director to be knowledgeable in dementia and what comes along with it with residents. The Director of Strategic Planning was informed of what the medical director stated regarding dementia residents and stated it was not necessarily okay to say that, but they would have to talk to the medical director and understand exactly what they meant by it; it was a situation that should be taken seriously.10NYCRR 415.15(a)(1)(2)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the Standard survey completed on 09/16/2025, the facility did not maintain an effective pest control program for four (4) (first, second, third, and fourth floors) of four (4) resident use floors. Issues included observations of evidence of rodents (dead rodents and rodent droppings) and flies.The findings are:The policy and procedure titled Pest Control, revised 7/2023, documented the facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. Pest control services are provided by an outside contracted pest control vendor. 1a. Observation on the first floor on 09/09/2025 at 1:40 PM and 09/16/2025 at 1:10 PM revealed rodent droppings were on the floor behind the door of the Dietary Storage Room. During an interview on 09/16/2025 at 1:10 PM, the Dietary Director stated on 09/08/2025, they personally moved chemicals, crates, and carboard in the area behind the door of the Dietary Storage Room. They stated it was possible that they disturbed some older rodent droppings that were behind the large metal cabinets, as there had been no recent rodent sightings in this room. The Dietary Director also stated this room was swept every Thursday, but the area behind the door needed to be swept again. 1b. Observation on the fourth floor on 09/11/2025 at 12:42 PM revealed rodent droppings on the floor in the corner to the right of the window of Resident room [ROOM NUMBER]. Further observation revealed the edge of the black cove base and the floor tile in this corner had small areas of damage, with black shavings on the floor around the droppings. During an interview at the time of the observation, the Regional Maintenance Director stated the black debris on the floor in the corner of Resident room [ROOM NUMBER] could be rodent droppings and shavings from the corner of the cove base, and the floor tile needed to be repaired in this corner. 1c. Observation on the third floor on 09/11/25 at 12:55 PM revealed there were rodent droppings on the floor at the foot of the left side bed inside Resident room [ROOM NUMBER]. Under the bed on the left side of the room were ripped sugar packets and ripped cookie packets. On the right side of the room, there were rodent droppings on the floor under the nightstand, in the bottom drawer of the nightstand, on the closet floor, and on the floor under the right-side bed. Also observed under the bed was a metal rodent trap box. Inside the metal rodent trap box was bits of bread, a crumpled paper towel, and four (4) small dead mice on glue paper. During an interview on 09/11/2025 at 2:00 PM, Resident #140 stated they had personally opened the metal rodent trap box but had had not done so in about a week. They stated they saw three (3) or four (4) mice running around their room, so they put bread into the box to catch the mice. Also at this same time, the Regional Maintenance Director stated they were unaware of the dead rodents inside Resident room [ROOM NUMBER] or the actions of the resident. The Regional Maintenance Director stated a different approach to rodent control would be needed in Resident room [ROOM NUMBER]. 1d. Observation on the third floor on 09/11/2025 at 1:25 PM revealed rodent droppings on the floor to the left of the dresser under the windows and rodent droppings on the floor to the right of the nightstand in the far-right corner of Resident room [ROOM NUMBER]. Continued observation revealed rodent droppings were also observed in the drawers of the nightstand in the far-right corner of Resident room [ROOM NUMBER]. 1e. Observation on the second floor on 09/11/2025 at 3:10 PM revealed there was an empty snack wrapper and rodent droppings on the floor behind the nightstand inside Resident room [ROOM NUMBER]. During an interview on 09/11/2025 at 3:10 PM, Resident #57 stated they saw a mouse two (2) days ago that ran from the closet area of their room to underneath their bed. 1f. Review of the outside contractor licensed exterminator's Service Inspection Report dated 08/05/2025 revealed it included the general comment/ instruction: upon inspection of room [ROOM NUMBER], it was found that mice had chewed through the rubber baseboard on the left side of the radiator. This was reported to maintenance and recommended sealing the hole. Observation on the fourth floor on 09/11/2025 at 12:35 PM revealed a small hole, approximately three-quarters of an inch in diameter, to the left of the radiator inside (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident room [ROOM NUMBER]. During an interview on 09/16/2025 at 8:15 AM, the Regional Maintenance Director stated they were not aware of the hole in Resident room [ROOM NUMBER] or the recommendation on the licensed exterminator's report to seal it. 2a. Observation on the third floor on 09/09/2025 at 9:56 AM revealed a fly in the nourishment area of the Dining Room. There was an insect light trap on the wall in the nourishment area. On the back of the insect light trap was a piece of glue paper that had at least 200 dead insects on it. At the time of the observation, the Maintenance Supervisor stated the facility had a contract with a licensed exterminator and the licensed exterminator maintained the insect light traps. They also stated the glue paper on this insect light trap needed to be changed. 2b. Observation on the third floor on 09/09/2025 at 10:15 AM revealed several live flies were flying around Resident #92 in their room. At the time of the observation, Resident #92 stated the flies bothered them, but they did not complain because they were moving out soon. 2c. During an observation and interview on the second floor on 09/09/2025 at 10:43 AM, Resident #10 was in their room in their wheelchair with their feet exposed on the foot pedals. Both feet had dressings on the heels, and their toes were exposed. Resident #10 stated the flies in their room were horrible. They felt the flies gravitated towards them because of the wounds on their feet. At this time, two (2) flies were observed in their room, hovering near Resident #10's feet. During a second observation and interview on 09/12/2025 at 10:00 AM, Resident #10 was in bed with hovering near them. Resident #10 stated the flies bothered them a lot. 2d. Observation on the second floor on 09/09/2025 at 11:25 AM revealed there was an insect light trap on the wall in the nourishment area of the Dining Room. On the back of the insect light trap was a piece of glue paper that had at least 200 dead insects on it. The insect light trap was plugged in, had a red status light illuminated, but no lights were illuminated inside the device. At the time of the observation, the Regional Maintenance Director stated the glue paper was full and the outside contractor was supposed to maintain the insect light traps. 2e. Observation on the first floor on 09/09/2025 at 1:15 PM revealed an insect light trap was on the wall in the Service Corridor, outside of the Dishwash Room. On the back of the insect light trap was a piece of glue paper that had at least 200 dead insects on it. At the time of the observation, the Regional Maintenance Director stated it was time to replace the glue paper. 2f. Observation on the first floor on 09/09/2025 at 1:20 PM revealed there were flies in the Dishwash Room. At the time of the observation, the automatic dishwasher was not running, and no dietary personnel were in the room. 2g. During an observation and interview on the fourth floor on 09/10/2025 at 9:04 AM, Resident #152 was lying in bed. There were several large black flies moving around on the tray table that was next to the bed. Additionally, there were more large black flies flying around the room, landing on the walls, the door to the bathroom, the windowsill and at times landing on Resident #152. Resident #152 was unable to be interviewed. During a second observation on 09/12/2025 at 8:17 AM, Resident #152 was lying in their bed and there were large black flies, flying around the room and landing on various objects in the room, the wall and the ceiling. During an interview on 09/12/2025 at 8:20 AM, Certified Nurse Aide #5 stated they had worked with Resident #152 and had noticed the flies in their room. They stated they were not sure where all the flies came from but think they were in the room because the resident uses a urinal. Certified Nurse Aide #5 stated that either maintenance or housekeeping were responsible for cleaning and pest control. As a Certified Nurse Aide, they stated their job was to notify the nurse on the cart whenever they see a lot of flies in a room and all the nurses on the unit were aware of the flies in Resident #152's room. During an interview on 09/12/2025 at 8:26 AM, Licensed Practical Nurse #3, stated they were aware of the live flies in Resident #152's room. They stated they believed there were a lot of flies in the room because Resident #152 would refuse care from time to time. Licensed Practical Nurse #3 stated when they saw flies in the room, the Certified Nurse Aide needed to change all the bedding, and a housekeeper was asked to clean the room. Licensed Practical Nurse #3 stated it was housekeeping's responsibility to keep the rooms clean to prevent flies. 2h. Observation on the fourth floor on 09/11/2025 at 11:55 AM revealed live flies in Resident room [ROOM NUMBER] and the bathroom of Resident room [ROOM (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NUMBER]. 2i. Observation on the second floor on 09/11/2025 at 3:20 PM revealed live flies in Resident room [ROOM NUMBER]. During an interview on 09/11/2025 at 3:20 PM, Resident #118 stated there were flies all over the place. Resident #118 also stated they ate meals in their room, the flies bothered them when they ate, and they had used a rolled-up piece of paper to whack the flies. 2j. Observation on the second floor on 09/11/2025 at 3:40 PM revealed flies flying around Resident #112's walker. At the time of the observation, Resident #112 stated they had flies in their room and sometimes it bothered them. 2k. Observation on the second floor on 09/11/2025 at 3:45 PM revealed a fly was flying between Resident #95's bed and window. At the time of the observation, Resident #95 was sitting on their bed and stated they ate their meals in their room and sometimes flies flew around them when they opened food containers, which bothered them. Review of the outside contractor licensed exterminator's Service Inspection Reports dated 09/05/2025, 08/29/2025, 08/22/2025, and 08/15/2025 revealed they included the general comment/ instruction: replace glue boards in all ILTs (insect light traps) and report any conditions conducive to small fly reproduction. The device inspection summary on all four (4) Service Inspection Reports indicated zero (0) of three (3) insect light traps were inspected. During an interview on 09/15/2025 at 2:24 PM, the Regional Maintenance Director stated the licensed exterminator came to the facility once per week. Their contract did include flies, and the insect light traps were installed by the former exterminating company, but the current exterminating company said they could service those devices. To their knowledge, the facility had four (4) insect light traps, one (1) in the nourishment area of each Dining Room and one (1) in the Service Corridor. The Regional Maintenance Director also stated they expected the current exterminating company to check the insect light traps each week. They stated they did not notice that this was not being done, according to their reports or the accumulation of flies on the insect light trap glue papers. During an interview on 09/15/2025 at 3:00 PM, the Administrator stated the facility's current outside contracted licensed exterminator did treat the facility for flies and did maintain the facility's insect light traps. The Administrator stated it was possible the licensed exterminator just was not recording it on their reports. The Administrator stated they had not personally looked at the glue boards on the insect light traps in a while, but they believed insect light traps were supposed to be checked weekly and the glue boards were supposed to be replaced monthly, or as needed, by the licensed exterminator. The Administrator stated they thought the licensed exterminator dated the glue boards with the date it was installed. The licensed exterminator also treated drains as a separate service, to control drain flies. On 09/15/2025 at 3:10 PM, the Administrator observed the insect light trap in the Service Corridor. They stated the glue board was not labeled with a date and there was still more room on the glue board, therefore it could continue to be used. During an interview on 09/16/2025 at 11:00 AM, the Administrator stated that they have been working on the rodent and fly problem in the facility. They stated they have a weekly exterminator visit. They stated they have provided plastic bags and bins for residents to store any food to prevent rodents from eating their food. They stated that they just hired a new Housekeeping Director who will be working on this issue. They stated that rodents and flies were part of the environment committee discussions that they have weekly. 10 NYCRR 415.29(j)(5)

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F 0584 Level of Harm - Minimal harm or potential for actual 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during a Complaint investigation (NY00370611-574668, NY00372414-574672, and 2563935) completed during the Standard survey on 09/16/2025, the facility did not provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable, and homelike environment. Specifically, there were areas of damaged walls and ceilings, dust laden fans inside resident rooms, soiled and sticky floors, and unpleasant odors. This affected three (3) (second, third, and fourth floors) of four (4) resident use floors.The findings are:The policy and procedure titled Homelike Environment, revised February 2021, documented residents are provided with a safe, clean, comfortable and homelike environment. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, including a clean, sanitary, and orderly environment and pleasant, neutral scents.The policy and procedure titled Cleaning and Disinfecting Residents' Rooms, revised August 2013, documented housekeeping surfaces (e.g. floors and tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environmental surfaces will be disinfected or cleaned on a regular basis and when surfaces are visibly soiled.1. Observation on the third floor on 09/09/2025 at 10:15 AM revealed the plaster ceiling in Resident room [ROOM NUMBER] had an area 6 feet in diameter that was discolored brown, cracked, and peeled down. Further observation revealed the area was near the end of Resident #92's bed.During an interview at the time of the observation, the Regional Maintenance Director stated the toilet above Resident room [ROOM NUMBER] overflowed one (1) to two (2) weeks ago and the overflow had been taken care of, but the damage to Resident room [ROOM NUMBER]'s ceiling still needed to be repaired and re-painted.During an interview on 09/16/2025 at 11:28 AM, Certified Nurse Aide #8 stated the ceiling damage in Resident room [ROOM NUMBER] had been like that for about a year, and it leaked on and off, but they were not sure when it last leaked.During an interview on 09/16/25 at 11:28 AM, Certified Nurse Aide #4 stated last week, they saw that the ceiling of Resident room [ROOM NUMBER] leaked and the floor was wet. They stated sometimes buckets were used to catch the water, and it was right next to a resident's bed and they were afraid that the resident might slip on the wet floor.Another observation and interview were conducted on 09/16/2025 at 9:27 AM in Resident room [ROOM NUMBER]. Both residents were in their bed during the observation. There was a large area of peeling and crumbling paint and plaster with brown areas on the ceiling above the residents bed that encroached into the other resident's side of the room. One resident stated the area only caused a hazard when it leaked, and the other resident stated it only leaked when it rained. Both residents stated they would not have a ceiling that look like that in their homes, it needed to be fixed and then painted. During an interview on 09/16/2025 at 9:29 AM, Registered Nurse #2 (Resident Care Coordinator of the third floor) stated the ceiling in Resident room [ROOM NUMBER] was appalling to have such a large area of peeling paint. They stated that having a ceiling that look like that might be okay in some homes, but it should not be like that in the facility. 2. Observation on the third floor on 09/09/2025 at 10:20 AM revealed brown, rust-like streaks appeared down the wall of the west corridor Tub and Shower Room. The streaks were in an area that was two feet wide by three feet long. Further observation revealed the ventilation fan in this room was not functional.At the time of the observation, the Regional Maintenance Director stated the streaks must be recent because this room was painted about three (3) weeks ago. They also stated they were unaware of the streaks on the wall or that the fan was not functional, and the fan would remove excess humidity in this room, which could help the situation.3. Observation on the second floor on 09/09/2025 at 11:38 AM revealed ceiling and wall plaster damage in the west corridor Tub and Shower Room. The area of ceiling damage was 3 feet in diameter and the area of wall damage was 18 inches long by 8 inches wide.At (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the time of the observation, the Regional Maintenance Director stated there was a leak from the floor of the shower above within the last two (2) months. Additionally, on 09/16/2025 at 1:25 PM, they stated the leak was fixed with silicone and held for one (1) to two (2) weeks but started leaking again. At the time of the second leak, about two (2) to three (3) weeks ago, epoxy grout was applied, which stopped the leaking.4. Observation on the fourth floor on 09/11/2025 at 12:25 PM revealed the drywall in Resident room [ROOM NUMBER] had been cut in rectangular areas that were 1 foot wide by 1 foot high and 2 feet wide by 2 feet high. The cut pieces of drywall were attached to the wall with black tape. Additionally, in this same room, there was an area of wall damage to the right of the window that was 12 inches high by 18 inches wide.At the time of the observation, the Regional Maintenance Director stated they were not aware of the wall cuts in Resident room [ROOM NUMBER] and was not sure why it was done. They stated the facility's maintenance staff did not do it, and if it was done by an outside contractor, they should have notified maintenance staff. The Regional Maintenance Director added that the area of wall damage to the right of the window was likely from the removal of a wall-mounted television.5. Observation on the third floor on 09/11/25 at 1:25 PM revealed the plaster ceiling in Resident room [ROOM NUMBER] had an area 2 feet in diameter that was discolored brown, cracked, and peeled down.6. Observation on the second floor on 09/11/25 at 3:20 PM revealed the plaster ceiling in the bathroom of Resident room [ROOM NUMBER] had an area 2 feet in diameter that was discolored brown and cracked.During an interview on 09/11/25 at 3:20 PM, the resident in room [ROOM NUMBER] stated sometimes there was water on the floor of their bathroom and they were not sure where the water came from. They stated the water takes over the corner, and I have no choice but to work around it if I want to use the bathroom.7. Observation on the third floor on 09/11/2025 at 12:55 PM revealed there were two (2) fans at the window side bed of Resident room [ROOM NUMBER]. The outside of the black fan was completely coated in a sticky-looking and dusty substance, and its louvers were coated in a thick layer of dust. The white fan had front and rear cages and blades that were coated in a thick layer of gray dust.At the time of the observation, the Regional Maintenance Director stated the fans should be cleaned by the facility's housekeeping staff, even if they belonged to the resident, and both fans in Resident room [ROOM NUMBER] needed to be cleaned.8. Observation on the second floor on 09/11/25 at 3:27 PM revealed a floor fan was on in Resident room [ROOM NUMBER] and the blades and front and rear cages were coated in a layer of dust.9. Observation on the second floor on 09/11/2025 at 3:40 PM revealed the wall along the left side of Resident room [ROOM NUMBER] was cracked with a piece missing in an area that was 2 feet high by 18 inches wide. Further observation revealed another area of wall damage below the first area behind a nightstand that was 1 foot high by 2 feet wide. There was also an area of peeled plaster on the ceiling that was 18 inches in diameter. These three areas were above and adjacent to the left side resident's bed.At the time of the interview, the Regional Maintenance Director stated the wall and ceiling damage in this room was related to the leak from the third floor west corridor shower that occurred within the last two (2) months.During an interview on 09/11/2025 at 3:40 PM, the resident in room [ROOM NUMBER] stated they did not like the way the wall and ceiling looked in their room.10. Observation on the fourth floor on 09/09/2025 at 9:08 AM and 11:13 AM revealed the Unit #4 floor felt sticky with multiple areas of brown and black debris. This affected three (3) of three (3) hallways and the area in front of the Nurses' Station. Unit #4 also had a urine odor that permeated the area. Observation on the third floor on 09/09/2025 at 11:23 AM and 4:06 PM revealed the floors on three (3) of three (3) hallways and the area in front of the Nurses' Station were sticking underneath feet and had multiple black and brown spots in various areas. During an interview on 09/09/2025 at 10:21 AM, Resident #74's representative stated that the floors were sticky and dirty. They stated that whenever they visited Resident #74, the unit always smells bad and that the facility could be cleaner. During an interview on 09/12/2025 at 8:55 AM, Resident #143 stated that the facility could be cleaner. They stated that the facility needed to clean the floors and the windows. During an interview on 09/12/2025 at 8:58 AM, Licensed Practical Nurse #3 stated that the floors (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could be cleaner. They stated that housekeeping was responsible for cleaning the floors. Licensed Practical Nurse #3 stated that they didn't believe the facility was homelike for the residentsDuring intermittent observations on 09/09/2025 to 09/16/2025 from 8:47 AM to 4:06 PM there was a noted pungent smell of urine and unpleasant body odor on the third floor when exiting off of the elevator, in the common area and at the Nurses' Station. During intermittent observations on 09/09/2025 to 09/16/2025 from 8:53 AM to 3:45 PM there was a noted pungent smell of urine and unpleasant body odor on the fourth floor when exiting off of the elevator, in the common area and at the Nurses' Station. During an interview on 09/10/2025 at 8:57 AM, Resident #9 stated they attempted to get out of bed a few times a week and when they were in the hallway of the third floor, it did not smell well. They stated the smell was not good and the unit had a smell of body odor. During an interview on 09/10/2025 at 10:31 AM, Resident #6 stated they did not feel their room or unit was homelike. They stated at times the hallway had a smell of urine and feces, and the unit needed a fresh paint job. During an interview on 09/10/205 at 11:23 AM, Resident #5 stated the unit was not clean. They stated that housekeeping did not mop the floors every day and the unit had a smell of urine and feces. During an interview on 09/12/2025 at 11:45 AM, Certified Nurse Aide #2 stated on 09/11/2025 they washed Resident room [ROOM NUMBER]'s floor. Certified Nurse Aide #2 stated a resident in that room would spill their urinal onto the floor and they washed the floor instead of housekeeping washing it, adding, I wanted it done (washed) the right way. They stated the third floor unit had an unpleasant odor of urine that was not homelike. During an interview on 09/15/2025 at 3:39 PM, Social Worker #1 stated there was a strong odor of urine and unpleasant body odor on the third floor and sometimes on the fourth floor. Social Worker #1 stated they have received complaints from the residents and family members about the unpleasant odors in the facility and that it does not present as a homelike environment. During an interview on 09/16/2025 at 8:18 AM, Certified Nurse Aide #1 stated the third floor had an odor mixed of urine and unpleasant body odor. They stated that the odor could come and go as long as all of the staff were during their jobs. They stated the smell did not provide a homelike environment, adding they would not want their house to have that type of odor.During an interview on 09/16/25 at 9:06 AM, Resident #155's spouse stated the facility occasionally had an odor of urine with sticky floors, especially on the fourth floor. They stated Resident #155 would urinate on their wall and bedroom floor. Resident #155's spouse stated when they came in to visit every night, they had to wash the resident's floor themselves. During an interview on 09/16/2025 at 9:46 AM, Director of Nursing #1 stated they frequently rounded on the units and there were occasional offensive odors in the facility. They stated the third and fourth floor units did not have a constant odor but there could be some odors at change of shift, when a resident had an incontinent episode, or when garbage or linen were being taken off the unit. During an interview on 09/12/2025 at 8:30 AM, the Assistant Administrator stated the facility's Environmental Services Director position was vacated within the last few weeks. They stated under the previous Environmental Services Director, housekeeping staff were assigned to different areas each day and they would work where the need was for that day. The Assistant Administrator stated a new Environmental Services Director was just hired.10 NYCRR 415.29

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview, observation, and record review conducted during a Standard survey completed on 9/16/2025, it was determined that the facility did not ensure that the resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. Specifically, one of three residents (Resident #5) reviewed for choices had issues with not receiving a shower for three weeks per their preference. The finding is:The policy and procedure titled Resident Rights dated 12/2016 documented that the resident has a right to self-determination.The policy and procedure titled Resident Rights Guideline for All Nursing Procedures dated 10/2010 documented that the resident has a freedom of choice.Resident #5 was admitted to the facility with diagnoses of paralysis of the right side of the body and depression. Review of the Minimum Data Set (a resident assessment tool) dated 6/19/2025 documented that the resident understands and is understood by others, cognitively intact, and requires maximal assist of staff for bathing.Review of the comprehensive care plan dated 11/12/2024 documented that Resident #5 was a maximal assist of two staff members for bathing their upper and lower body.Review of the Certified Nurse Aide closet care plan dated 09/16/25 documented that Resident #5 was an extensive assist of two staff members for bathing their upper and lower body. The closet care plan documented that the resident was to receive a shower once a week. Review of the interdisciplinary progress notes dated 08/19/2025 to 09/16/2025 revealed that there was no documentation that the nurse performed a skin check during this time. The progress notes revealed that there was no documentation that the resident refused a shower.Review of the shower sheet schedule dated 09/12/2025 documented that the resident was to receive a weekly shower on the 7:00 AM to 3:00 PM shift every Monday. During an interview on 09/10/2025 at 9:33 AM with Resident #5, they stated that they haven't had a shower in three weeks, and they wanted one. They stated that they are supposed to get a shower on Monday. During an interview on 09/16/2025 at 7:41 AM with Certified Nurse Aide #4, they stated that if a resident doesn't get a shower, then they should get one on the next shift. They stated that Resident #5 just moved rooms and that might have messed up their shower schedule. They stated that they would tell the nurse if the resident refused a shower. During an interview on 09/16/2025 at 7:44 AM with Licensed Practical Nurse #7, they stated that they reviewed the progress notes and weekly skin check wasn't documented that it was completed for Resident #5. They stated that it is important that a resident's skin is checked weekly so they can prevent skin breakdown. During an interview on 09/16/2025 at 7:48 AM with Resident #5, they stated that they didn't receive a shower last night. They stated that they wanted a shower last night and it bothered them they didn't get one. During the interview, it was observed that Resident #5's hair appeared greasy and unkempt. During an interview on 09/16/2025 at 8:05 AM with Director of Nursing #1, they stated that it was important for a resident to get showers, so they got their skin checked to prevent skin breakdown. They stated they would expect nursing staff to document the weekly skin check in progress notes. 10 NYCRR 415.5(b)(1-3)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review during the Standard survey completed on 09/16/2025, the facility did not implement written policies and procedures for screening employees that would prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Specifically, the facility did not provide documentation that verified three (3) (Registered Nurse Supervisor #1, Unit Clerk #1, and Dietary Supervisor #1) of eight (8) employees reviewed that worked in the facility and were subject to the New York State Nurse Aide Registry had been screened through the New York State Nurse Aide Registry prior to their first date worked at the facility.The findings are:The policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, documented the resident abuse, neglect and exploitation prevention program consisted of a facility-wide commitment and resource allocation to support its objectives. The objectives included developing and implementing policies and protocols to prevent and identify abuse, neglect, or mistreatment of residents or theft, exploitation or misappropriation of resident property. The facility will conduct employee background checks and not knowingly employ or otherwise engage any individual who has had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. 1a. Review of Dietary Supervisor #1's personnel file revealed it contained no documentation that a New York State Nurse Aide Registry check was performed for Dietary Supervisor #1, who was a full-time employee at this facility between 04/08/2025 and 04/25/2025. During an interview on 09/11/2025 at 11:12 AM, the Administrator stated the Nurse Aide Registry should be checked for all employees before they start working at this facility. The Administrator also stated they believed they personally checked the New York State Nurse Aide Registry for Dietary Supervisor #1 upon hire but could not locate the paperwork or digital record at this time. 1b. Review of Unit Clerk #1's personnel file revealed it contained no documentation that a New York State Nurse Aide Registry check was performed for Unit Clerk #1, who was a full-time employee at this facility between 04/08/2025 and 06/05/2025.1c. Review of Registered Nurse Supervisor #1's personnel file revealed it contained no documentation that a New York State Nurse Aide Registry check was performed for Registered Nurse Supervisor #1. Registered Nurse Supervisor #1 was a per-diem employee who started working at the facility on 04/08/2025 and was still actively employed, but their last date worked was 05/05/2025. During an interview on 09/11/2025 at 11:15 AM, the Human Resources Director stated they did not work at this facility at the time Dietary Supervisor #1, Unit Clerk #1, or Registered Nurse Supervisor #1 were hired, but the current procedure in place was that they looked up each new hire's name on the New York State Nurse Aide Registry and printed the verification sheet before their start date. Additionally, on 09/15/2025 at 10:10 AM, the Human Resources Director stated they could not locate a documented Nurse Aide Registry check for Dietary Supervisor #1, Unit Clerk #1, or Registered Nurse Supervisor #1.415.4(b)(1)(ii)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review conducted during a Standard survey completed on 9/16/2025, the facility did not ensure that comprehensive care plans included to the extent practicable, the participation of the resident and the resident's representative(s); an explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan; and were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for two (2) (Residents #29 and #74) of two (2) residents reviewed for care plan participation and care plan revision related to accidents. Specifically, Resident #74's representative was not invited to participate in care plan meetings and Resident #29's care plan was not revised when the resident was removed from one to one supervision after they transferred to a secure unit. The findings are:The undated document titled Social Worker documented that a Social Worker under job knowledge and responsibilities demonstrates the ability to adjust to changes to unit/shift assignments to meet resident and resident families' needs. It documented that the Social Worker is to attend and lead patient care conference meetings within 21 days of a resident's admission. It documented that the Social Worker is to work directly with family or responsible party to enhance functioning of a resident in the facility.The policy and procedure titled Resident Rights Guidelines for All Nursing Procedures dated 10/2010 documented that staff must have appropriate in-service training on resident rights including resident and family participation in care planning.The policy and procedure titled Care Plans, Comprehensive Person-Centered dated 3/2022 documented that residents have the right to participate in the planning process and be able to request meetings.1. Resident #74 was admitted to the facility with diagnoses of vascular dementia, anxiety and depression. Review of the Minimum Data Set (a resident assessment tool) dated 07/03/2025 documented that the resident was severely cognitively impaired, usually understands others, and was usually understood by others. Review of the Social Work progress notes from 12/31/2024 to 4/1/2025 revealed no documented evidence of an invitation sent to the resident or the resident's representative for a care plan meeting.During an interview on 9/9/2025 at 10:21 AM with Resident #74's representative, they stated that they have not been invited to a care plan meeting since Resident #74's admission and they would like to attend.During an interview on 9/12/2025 at 9:43 AM with the Social Worker, they stated that they did not invite Resident #74's representative to care plan meetings. They stated that they would document in their progress notes if they invited them. They stated that they were covering the entire building and that the invitation for a care plan meeting would have fallen through the cracks.During an interview on 9/16/2025 at 11:00 AM with the Administrator, they stated that Social Work was responsible for inviting residents and or their representative to care plan meetings. They stated that Social Work has been educated to invite residents or their representatives and to document that invitation in progress notes.2. The facility policy and procedure titled Care Plans, Comprehensive Person-Centered dated March 2022 documented a comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical , psychosocial and functional needs was developed and implemented for each resident. The policy documented the assessment of residents was ongoing and care plans were revised as information about the residents and the residents' conditions change.Resident #29 had diagnoses that included Wernicke's encephalopathy (serious neurologic disorder caused by thiamine deficiency often linked to chronic alcohol abuse), alcohol dependence and type II diabetes. The Minimum Data Set (a resident assessment tool) dated 06/30/2025 documented the resident had severe cognitive impaired, was understood and understands. Review of the Comprehensive Care Plan with date initiated 5/26/2025, documented Resident #29 was at risk for elopement related to elopement assessment and/or attempt. Interventions included apply wander detection system bracelet and check every shift; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluate activity preferences; post resident picture on the facility risk book at reception; place resident on one-to-one observation; and resident would be considered for a secured unit.Review of the facility's investigation summary dated 05/29/2025, Director of Nursing #1 documented Resident #29 had an elopement from the facility on 05/26/2025 at 9:35 AM. Resident #29 was found in front of the corner store by a staff member when they were on a break. The investigation summary follow-up actions documented Resident #29 was placed on one-to-one supervision until a room change to the fourth floor occurred. One to one was discontinued after wander guard placement.Review of the facility's incident report dated 5/26/2025 at 9:35 AM, Director of Nursing #1 documented in the notes section of the report on 5/29/2025 that Resident #29 was placed on the fourth floor, one to one was removed and a wander guard was placed on the resident.During an interview on 09/11/2025 10:53 AM, Registered Nurse #1 (Resident Care Coordinator of the fourth floor) stated when Resident #29 was moved to their floor at the end of May 2025 they placed a wander guard on the resident because the resident had eloped from the facility a few days prior. Registered Nurse #1 stated the Resident Care Coordinators were responsible for care plan development and revision and therefore they were responsible for Resident #29's comprehensive care plan. They stated a resident's care plan would be reviewed according to a resident's minimum data set schedule. During a further interview on 09/15/2025 at 3:45 PM, Registered Nurse #1 reviewed Resident #29 comprehensive care plan in the electronic medical record and stated Resident #29's comprehensive care plan documented Resident #29 had an elopement from the facility and an intervention for the resident was to be place on a one-to-one observation. Registered Nurse #1 stated that was not an accurate intervention because the one to one had been discontinued after Resident #29 was transferred to unit four. They stated Resident #29's care plan was not updated and revised, it should have been, and they needed to correct it.During an interview on 09/15/2025 at 3:54 PM, Director of Nursing #1 stated on 05/26/2025 Resident #29 was placed on a one-to-one observation until the resident was moved to the fourth floor and a wander guard was placed. After review of the paper copy of Resident #29's comprehensive care plan, Director of Nursing #1 stated the intervention of a one-to-one observation for Resident #29 was no longer an active intervention as a result of the resident's elopement. They stated the comprehensive care plan was not revised timely and it would be the responsibility of Registered Nurse #1 to update Resident #29's care plan so proper interventions were in place. 10NYCRR 415.11(c)(2)(ii-iii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review conducted during the Standard survey completed on 9/16/25, the facility did not ensure that each resident received treatment and care in accordance with professional standards of practice for one (1) (Resident #88) of one (1) resident reviewed for positioning. Specifically, while sitting in their wheelchair, Resident #88's feet were hanging down and were approximately four (4) to six (6) inches from touching the floor for extended periods of time.Based on observation, interview, and record review conducted during the Standard survey completed on 9/16/25, the facility did not ensure that each resident received treatment and care in accordance with professional standards of practice for one (1) (Resident #88) of one (1) resident reviewed for positioning. Specifically, while sitting in their wheelchair, Resident #88's feet were hanging down and were approximately four (4) to six (6) inches from touching the floor for extended periods of time. The finding is: The policy and procedure titled Repositioning revised May 2013 documented repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Evaluate resident who can reposition independently to determine the following: is a positioning device needed to maintain independent positioning. Resident #88 was admitted with diagnoses hemiplegia (paralysis on one side of the body) and hemiparesis (weakness of one side of the body) affecting the right dominant side, cerebral infarction (stroke), and aphasia (absence or difficulty with speech). The Minimum Data Set (a resident assessment tool) dated 8/5/25 documented Resident #88 was usually understood, usually understands and was severely cognitively impaired. Resident #88 required partial/moderate assistance for transfers and was dependent on staff for lower body dressing and putting on/taking off footwear. The comprehensive care plan dated 3/23/23 documented Resident #88 had limited physical mobility. Interventions were revised on 9/11/25 to include locomotion on unit: extensive assist of one (1) staff member with a manual wheelchair with a calf board. Additionally, Resident #88 had a communication problem related to aphasia. Interventions included anticipate and meet needs. Review of the Kardex (guide used by staff to provide care) dated 9/10/25 documented the resident required extensive assist of one (1) staff member with a manual wheelchair for locomotion. During a continuous observation and interview on 9/9/25 from 12:46 PM until 1:19 PM, Resident #88 was in the dining room sitting in their wheelchair. Resident #88 smiled but was unable to answer any questions. The leg rests attached to the wheelchair were extended straight out from the wheelchair. Resident #88's legs were straight down, and their feet were not touching the floor. Their feet were pointed downwards with their toes approximately four (4) inches from the floor. Occasionally, Resident #88 would move their right leg upwards, reaching towards the leg rest but was unable to raise the leg onto it. During a continuous observation on 9/11/25 from 11:00 AM until 2:01 PM, Certified Nurse Aide #13 wheeled Resident #88 from their room to a table in the dining room. Both wheelchair leg rests were attached and extended straight out from the wheelchair. Resident #88's left leg was on the leg rest and the right leg was hanging down, not touching the floor while the wheelchair was moving. When they stopped at the table, Certified Nurse Aide #13 walked away and Resident #88's left leg fell off the leg rest. They attempted to lift their leg back up but were unable to. Both of Resident #88's feet were pointed downwards at an angle with their heels approximately six (6) inches from the floor and their toes approximately four (4) inches from the floor for the remainder of the observation. At times, Resident #88 alternated placing the bottom of one foot on top of their other foot. During an interview on 9/11/25 at 2:06 PM Certified Nurse Aide #13 stated they were responsible for Resident #88's care and their legs should have been on the leg rests so their feet could rest. Certified Nurse Aide #13 stated that Resident #88's right leg always slid off the leg rest but sometimes the left leg would stay on it. Certified Nurse Aide #13 stated they thought Resident #88 would have been able to complain if their legs bothered them. They stated that the leg rests were always extended straight out and never (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	down but the leg rests should have been in a downward position so Resident #88 could reach them. Certified Nurse Aide #13 stated they thought everybody already knew that Resident #88's leg rests looked like that, and Resident #88 was unable to hold both of their legs on the leg rests for a long time. During an interview on 9/12/25 at 8:31 AM Licensed Practical Nurse #3 stated both of Resident #88's feet and legs should have been supported. Sometimes one leg was on the leg rest and sometimes it was not. Licensed Practical Nurse #3 stated Resident #88's legs would hang down because Resident #88 was very short, the wheelchair was higher because of the cushion and the wheelchair leg rests were so long for Resident #88.During an interview on 9/12/25 at 11:13 AM Registered Nurse #1 Resident Care Coordinator stated Resident #88's wheelchair leg rests should not have been straight out and should have been angled downwards so that Resident #88 could rest their feet on them. Their legs and feet should have been supported for good circulation and to prevent foot drop or any contractures. During an interview on 9/15/25 at 8:54 AM the Director of Rehabilitation stated they were notified by Registered Nurse #1 Resident Care Coordinator on 9/11/25 to look at Resident #88's positioning in their wheelchair. They stated they assessed Resident #88's positioning and they noticed the wheelchair leg rests were straight out and extended longer than they should have been, they were not angled downwards. Even if the wheelchair leg rests were angled downwards, they would have still been too long and Resident #88's feet would not be able to touch the pedals. During the assessment, they stated Resident #88 had a tendency of pulling their leg in and they felt a calf board would be more comfortable. They stated when it was observed that Resident #88 alternated placing one foot on top of the other, that could have indicated discomfort. The Director of Rehabilitation stated residents were evaluated quarterly by the therapy department but for any new problems, it was the responsibility of the certified nurse aide to notify either a nurse or the therapy department of any concerns with a resident. They stated usually the certified nurse aide would let the nurse know and then it would be discussed in morning report. During an interview on 9/15/25 at 10:52 AM, Director of Nursing #1 stated they expected all residents to be positioned appropriately in an upright position while in their wheelchair and be repositioned as needed. It was the responsibility of any staff member who noticed Resident #88's feet being unsupported to say something to a manager or the therapy department. Resident #88's legs and feet should have been supported for comfort. During a telephone interview on 9/15/25 at 11:55 AM, Nurse Practitioner #2 stated they expected staff to ensure Resident #88's legs and feet were supported for their comfort. They stated Resident #88 was unable to verbalize their needs and should have had some form of support to prevent them from becoming uncomfortable. During an interview on 9/15/25 at 1:20 PM, the Administrator stated they expected all staff on the units to ensure residents were positioned correctly in their wheelchairs. They stated any staff who noticed a resident was not positioned correctly should contact a certified nurse aide or a nurse and they were responsible to reposition the resident. 10NYCRR 415.12

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview, and record review conducted during the Standard survey, completed on 09/16/2025, it was determined that the facility did not ensure that residents received proper treatment and assistive devices to maintain vision abilities; and if necessary, must assist the resident in making appointments for one (1) (Resident #57) of one (1) resident reviewed for treatment/services to maintain vision. Specifically, the facility did not act on the optometry recommendations for cataract surgery for Resident #57 from 10/29/2024 and again on 06/10/2025. The finding is:The policy titled Resident Rights, last revised December 2016, documented federal and state laws guaranteed certain basic rights to all residents of the facility. Those rights included the residents right to a dignified existence and communication with and access to people and services, both inside and outside the facility.The facility did not have any policies regarding hearing or vision, consultants or outside consults, or provider recommendations.Resident #57 had diagnoses including schizoaffective disorder (a mental health condition), diabetes mellitus type two (2), and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 06/13/2025 documented Resident #57 was cognitively intact, was understood, understands and had adequate vision.The comprehensive care plan dated 12/18/2024 documented Resident #57 was independent for ambulation for unlimited distances with their personal four (4) wheeled walker. There was nothing related to vision on the comprehensive care plan.Review of the outside consult form dated 10/29/2024 revealed Resident #57 was recommended by Ophthalmologist #2 for cataract surgery in both eyes. This form had an undated signature by Nurse Practitioner #1.Review of the facility eye consult form dated 04/24/2025 revealed Resident #57 told Ophthalmologist #1 they were waiting to have their cataract surgery but was unsure when it was scheduled for. Ophthalmologist #1 documented please keep cataract surgery plans for patient. Keep was underlined three (3) times. This form had an undated signature by Nurse Practitioner #1.Review of the Ophthalmology consult form dated 06/10/2025, revealed Ophthalmologist #2 documented Resident #57 stated when they read something close there was not enough contrast on the page/paper and they could not read it unless they used more light to see the contrast on the things they are reading. Occasionally they would see a line floating in their vision. Resident #57 had cataracts/anatomic narrow angles in both eyes. The cataracts were causing blockade of drainage channels, Resident #57 was at risk for angle closure, also causing vision to blur. Resident #57 would benefit from cataract surgery. Discussed cataract surgery versus Laser Peripheral Iridotomy (laser eye surgery that treats closed angles). Last time, Resident #57 was planned for cataract surgery in 10/2024, but could not reach out to Rehab facility, fell through cracks, so it was better to do Laser Peripheral Iridotomy in the interim while waiting cataract surgery. Follow up in one (1) to two (2) weeks. This form had an undated signature by Nurse Practitioner #1.Review of facility eye consult form dated 07/25/2025 revealed Ophthalmologist #1 documented Resident #57 needs to continue care with Ophthalmologist #2, needs Laser Peripheral Iridotomy to both eyes and cataract surgery ASAP (as soon as possible).During an interview on 09/09/2025 at 8:59 AM, Resident #57 stated I am going blind, and no one is doing anything. Resident #57 stated they saw the eye doctor, but the facility was dragging their feet and my eyes are getting worse by the day. Resident #57 stated they were supposed to have cataract surgery a while back but now the ophthalmologist recommended laser eye surgery, but nothing had been done yet regarding either. They gave their paperwork to the person at the desk when they got back from the appointment and has heard nothing since. During an interview on 09/15/2025 at 10:01 AM, Registered Nurse #4 (Resident Care Coordinator) stated they were unaware that Resident #57 was supposed to be scheduled for Cataract surgery; they had not seen the consult form sent from Ophthalmologist #2 on 06/10/2025 and was not working in the facility when the initial recommendation was made in October of 2024. Registered Nurse #4 stated the process for all consults was the unit managers went through the consults and reviewed them, updated the providers on any new recommendations, then the consults went into the (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	providers folder to be reviewed. After the provider reviewed them, the consults would go to the Director of Medical Records who then scanned them into the computer and made any follow up appointments necessary. Registered Nurse #4 stated it was very important for Resident #57 to have the cataract surgery because their vision is impaired, and they should not have to deal with that.During an interview on 09/15/2025 at 10:15 AM, the Director of Medical Records stated they did not know how Resident #57s appointment for their cataract surgery was never scheduled, I did not have anything written down after Resident #57 returned from their appointment, it must have fell through the cracks. The Director of Medical Records stated typically the unit manager would tell the unit clerk who needed what appointment scheduled and the unit clerk would be responsible for scheduling all appointments, but the second and third floors did not have a unit clerk until very recently, so the Director of Medical Records was scheduling all appointments for residents in the interim. Director of Medical Records stated they did not know why the appointment from October 2024 was never scheduled, there During a telephone interview on 09/15/2025 at 11:34 AM, Nurse Practitioner #1 stated they reviewed all consults and signed them, then they expected them to be reviewed by the unit managers and then the Director of Medical Records made any appointments necessary. Nurse Practitioner #1 stated they agreed with Ophthalmologist #1 and Ophthalmologist #2 recommendations; Resident #57 should not have had to wait since October of 2024 for their cataract surgery and it was important for Resident #57 to have their cataract surgery so that their quality of life could be sustained.During an interview on 09/16/2025 at 9:28 AM, Director of Nursing #1 stated the unit managers were responsible for following through with all recommendations made from providers and outside consultants, like the Ophthalmologist. Director of Nursing #1 stated Resident #57 should have been scheduled for their cataract surgery in October of 2024, but there were changes with staff, including unit managers and unit clerks, so it was possible that played a role in the appointment not being scheduled. Director of Nursing #1 stated they did not know why Resident #57s appointment was not scheduled after their appointment in June of 2025, but it was important for Resident #57s cataract surgery to be scheduled as soon as possible to improve their vision and quality of life.During a follow up interview on 09/16/2025 at 12:16 PM, Director of Nursing #1 stated the facility did not have any policies regarding consults, vision, or following provider recommendations.10 NYCRR 415.12(b)(1-2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review conducted during a Complaint investigation (Complaint #NY00381662-574015) during the Standard survey on 09/16/2025, the facility did not ensure the resident's environment remained free from accident hazards over which the facility had control and provide adequate supervision to prevent accidents for one (1) (Resident #29) of one (1) resident reviewed for elopement. Specifically, on 05/26/2025 Resident #29 had exited the facility through a service door, out of a fenced gate and was found at the local corner store. Additionally, Resident #29 was observed not wearing their wander guard as care planned, wander guard checks were not implemented for placement every shift, and the 11:00 PM-7:00 AM wander guard checks for functionality were not implemented. The finding is:The policy and procedure titled Wandering and Elopements, last revised March 2019, documented the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The policy and procedure titled Elopement Security System alarms/devices, last revised 7/2024, documented security alert devices are used to alert staff to resident movement outside a designated area. The alarm devices will be assessed at regular intervals to insure proper functions. The policy documented all code alert bracelet alarms that are in use will be checked daily by nursing staff by using the hand-held transmitter tester or as otherwise stated in the manufacturer's direction and the findings would be recorded on the code alert log. The policy documented the wander guard devices will be monitored by the med/treatment nurse every shift by placing it on the TAR (electronic treatment administration record). Location/placement of the devices will also be identified and checked. Resident #29 had diagnoses that included Wernicke's encephalopathy (serious neurologic disorder caused by thiamine deficiency often linked to chronic alcohol abuse), alcohol dependence and type II diabetes. The Minimum Data Set (a resident assessment tool) dated 04/25/2025 documented the resident had severe cognitive impairment, was understood, understands and did not display any wandering behaviors.Review of the Comprehensive Care Plan with initiated date 5/26/2025, documented Resident #29 was at risk for elopement related to elopement assessment and/or attempt. Interventions included to apply a wander detection system bracelet and check it every shift; evaluate activity preferences; post resident picture on the facility risk book at reception; place resident on one-to-one observation; and the resident would be considered for a secured unit. The care plan documented Resident #29 had impaired cognitive function or impaired thought process related to altered mental status and was alert and oriented x 1 (to self). There was nothing documented regarding the resident removing their wander guard bracelet.Review of the kardex (residents) care guide dated 05/25/2025 documented Resident #29 was a limited assist of one (1) person with a two (2) wheeled walker for transfers and a limited assist of one (1) person with a manual wheelchair for locomotion.Review of the Elopement Evaluation dated 04/22/2025 revealed the resident scored a 0 (no risk), on 05/26/2025 they scored a 6 and on 06/30/2025 they scored a 3. All three assessments documented that a score of 1 or higher indicated a resident was at risk for elopement and all three assessments had no interventions marked under the clinical suggestion section. The nursing Progress Note dated 05/26/2025 at 12:26 PM, written by the Assistant Director of Nursing, documented a certified nurse aide, that was on their break, found Resident #29 in their wheelchair outside of a store about two blocks from the facility. Certified Nurse Aide stayed with Resident #29 until the Assistant Director of Nursing arrived at the store. Resident #29 was returned to the facility with no injuries or distress. The note documented Resident #29 stated they exited through a side door, pointed they went down the main elevator, through double door while someone held the door open and down the kitchen hallway. Resident #29 pointed to the service/delivery entrance door which was slightly open and not alarming. The note documented maintenance locked and secured the door with the alarm. Review of the facility's investigation summary dated 05/29/2025, revealed Director of Nursing #1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented Resident #29 had an elopement from the facility on 05/26/2025 at 9:35 AM and was last seen in the facility around 8:00 AM. The investigation summary follow-up actions documented Resident #29 was placed on a one-to-one until a room change to the fourth floor occurred. One-to-one was discontinued after the wander guard placement.Review of the medical providers orders dated 09/11/2025 at 11:28 AM documented Resident #29 had an order for wander guard placement checks every shift for an elopement risk. The order documented it was an active order with start date of 09/10/2025.Review of the Wanderguard check list (night nursing supervisor log for checking functionality of wander guard) from 06/01/2025-09/10/2025 documented Resident #29 was not being monitored until 09/10/2025. Per an internet-based map application the distance from the facility to where the resident was located at the corner store was 0.1 miles away or a three-minute walk.During observations and interviews at 09/09/2025 at 9:50 AM and 09/10/2025 at 11:00 AM Resident #29 was in their room either sitting on their bed or in a straight back chair. The resident was pleasantly confused and stated they had never left the facility and went to the corner store. During an observation on 09/10/2025 at 3:39 PM, Resident #29 did not have a wander guard bracelet on their wrists and/or ankles nor was a wander guard bracelet observed on the resident's wheelchair or walker. Resident #29 stated that they do not wear any bracelets showing their bilateral wrists and ankles. During an interview on 09/10/2025 at 4:18 PM, Certified Nurse Aide #11 stated they were familiar with Resident #29 and Resident #29 did not wear a wander guard bracelet and the resident never leaves their room. Certified Nurse Aide #11 stated they would know if a resident was supposed to be wearing a wander guard just by observing them for exit seeking behavior. Certified Nurse Aide #11 stated they would know if a resident was to have safety interventions in place by reading the residents plan of care in their electronic medical record. After they reviewed Resident #29's plan of care in the electronic medical record, Certified Nurse Aide #11 stated Resident #29 was care planned to wear a wander guard and the location of the bracelet was not documented.During an interview and observation on 09/10/2025 at 4:25 PM, Licensed Practical Nurse #6 stated they were familiar with Resident #29 and Resident #29 usually did not wear a wander guard and they have never seen the resident attempt to leave the unit. They stated the order to check Resident #29's wander guard was just implemented into the electronic medication administration record a few moments ago. Licensed Practical Nurse #6 entered Resident #29 room, and it was observed that the resident was now wearing a wander guard bracelet to their left ankle. Licensed Practical Nurse #6 stated the wander guard was just place on Resident #29, but they were unsure by who and was unsure who just implemented the checks into the electronic medical record.During an interview on 09/11/2025 10:53 AM, Registered Nurse #1 (Resident Care Coordinator of the fourth floor) stated they placed a wander guard bracelet on Resident #29 on 09/10/2025 and put an order into the electronic medication record for the wander guard to be monitored for placement every shift. They stated they were not sure what time they applied the wander guard bracelet but did so because Resident #29 was not wearing one. They stated they had applied a wander guard to Resident #29 when the resident was moved to the 4th floor the end of May 2025. Registered Nurse #1 stated Resident#29 had a tendency to remove their wander guard bracelet, and they have even attempted to place it on the resident's wheelchair. Registered Nurse #1 stated they also put an order in the electronic medication record to monitor the wander guard placement every shift on 09/10/2025 because it was the facility procedure to do so, and the resident did not have an order. During a further interview on 09/15/2025 at 3:45 PM, Registered Nurse #1 stated they did not recall if they told a nursing supervisor that they placed a wander guard on Resident #29 as they should have. They stated they should have informed the nursing supervisor so the night nursing supervisor could check the wander guard and ensure it was working.During an interview on 09/16/2025 at 8:38 AM, the Minimum Data Set Coordinator stated they would supervise the facility often on the 11:00 PM- 7:00 AM shift. They stated one of the overnight supervisor duties was to check the wander guards that were placed on residents for functionality. The Minimum Data Set Coordinator stated you would slide a box over the wander guard and a light (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would indicate if it was working. They stated they had never checked Resident #29 for wander guard function and did not believe the resident had a wander guard. During an observation and interview on 09/12/2025 at 11:09 AM, the Regional Maintenance Director along with the Maintenance Supervisor #1 observed the service receiving door Resident #29 was believed to exit from. The door contained a numeric code magnetic lock that required a digit code to exit. Outside the door was a small dumpster to the left and after about 12 steps was a fence with a gate. The Regional Maintenance Director stated after the incident they installed the code magnetic lock to the door and installed a camera facing the door. They stated they also installed a lock on the gate. The Regional Maintenance Director stated if the door was not shut properly, and the fence was open a resident could have gotten out of the door and away from the facility. During a further interview on 09/16/2025 at 1:25 PM, the Regional Maintenance Director along with the Maintenance Supervisor #1 stated when Resident #29 exited the building the service receiving door had a regular door lock and when the door was opened a ringing sound would occur. They stated to disable the ringing noise a key would need to be inserted into the box and turned to off. The Maintenance Supervisor #1 stated they believe someone had turned the box to the off position and the door did not ring when Resident #29 had exited the building in May 2025. During an interview at 09/16/2025 at 1:47 PM, Maintenance Staff #1 stated they assessed the service door on 05/26/2025 after the request by the Assistant Director of Nursing because a resident had exited the facility through that door. Maintenance Staff #1 stated the door was cracked open and the alarm was not ringing. They stated the alarm was turned to the off position and they were unsure who had turned the alarm to off. Maintenance Staff #1 stated they shut the door fully and reset the alarm position to on. During an interview on 09/15/2025 at 3:54 PM, Director of Nursing #1 stated on 05/26/2025 Resident #29 was located at the corner store around 9:30 AM. They stated Resident #29 left the facility via the service door and out a gate by the facility's dumpster that was in front of the building. They stated the door was not secure and the gate was unlocked and if the door and gate were secure, it could have prevented Resident #29 from exiting the building. Director of Nursing #1 stated the resident was placed on a one-to-one until they were moved to the fourth floor and a wander guard was placed. They stated Resident #29 should have been wearing the wander guard during the observation on 09/10/2025 at 3:39 PM because it was the intervention that was put into place after the incident. They stated Resident #29 should have also had wander guard checks for placement every shift put into the electronic medication record. Director of Nursing #1 stated Resident #29 should have also been placed on the 11:00 PM - 7:00 AM wander guard log checks for the nursing supervisor to ensure the wander guard was functioning properly. They stated this would have been the responsibility of Registered Nurse #1 to complete. Director of Nursing #1 stated they were unsure why Registered Nurse #1 did not implement those items but should have. During an interview on 09/15/2025 at 4:13 PM, the Administrator stated Resident #29 exited the facility in May 2025. After review of the facility investigation folder and nursing progress note, the Administrator stated Resident #29 came down the main elevator where an unknown staff member held the double door open for the resident to enter the service hallway. Resident #29 then went out of the service door. They stated at that time the service door had an alarm that would alarm when the door opened. The Administrator stated they were unsure why the alarm did not ring, but Resident #29 should have not gotten out of the service door. They stated they would expect all care planned interventions be in place unless they were discontinued, including Resident #29's wander guard. They stated they would expect Resident #29's wander guard checks to be on the medication administration record and on the 11:00 PM -7:00 PM nurse supervisor checks log if it was the facility's policy to do so.During a telephone interview on 09/15/2025 at 6:17 PM, the Assistant Director of Nursing stated on 05/26/2025 Certified Nurse Aide #12 called them to tell them Resident #29 was in front of a store in their wheelchair. The Assistant Director of Nursing stated they met Resident #29 and Certified Nurse Aide #12 at the store which took about 10 minutes to walk there and returned the resident to the facility. They stated Resident #29 showed them they went down the main elevator, through the double (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doors to the service hallway and out the side service door. The Assistant Director of Nursing stated upon inspection of the service door it was shut but not locked and the alarm was not sounding. During a further interview on 09/16/2025 at 1:32 PM, the Assistant Director of Nursing stated they had maintenance look at the service door after their initial inspection and they also interviewed the dietary staff. They stated the staff denied turning the service door alarm off and/or holding the double doors opened for Resident #29 to enter the service hallway.During a telephone interview on 09/15/2025 at 5:00 PM, Medical Doctor #1 stated they were familiar with Resident #29 and could not recall the details around the incident when the resident exited the building and was found at the corner store. They stated that Resident #29 did not have the capacity to leave the building unsupervised in May 2025 and they would expect that all care planned intervention would remain in place for the resident's safety. 10 NYCRR 415.12(h)(2)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review conducted during an Extended survey completed on 10/10/2025, the facility did not ensure that each resident received the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being for two (2) (Residents #6 and #155) of five (5) residents reviewed. Specifically, Resident #6 was not receiving psychotherapy services and/or group therapy services as recommended by their psychiatry provider and there was a delay in obtaining a follow up psychiatry consult as recommended for Resident #155. The findings are:The undated policy titled Resident Rights documented federal and state laws guarantee certain basic rights to all residents of the facility. The policy documented those rights included the resident right to self-determination; be informed of, and participate in, his/her care planning and treatment; and participate in decision-making regarding his/her care. 1.Resident #6 had diagnoses that included bipolar, major depressive disorder and generalized anxiety disorder. The Minimum Data Set, dated [DATE] documented Resident #6 was cognitively intact, was understood, and understands. The Comprehensive Care Plan revised date 02/05/2024, documented Resident #6 was alert and oriented with intact cognition, and was independent in decision making. Interventions included to participate in activities to promote socialization and encourage resident to continue to verbalize their wants and needs. Resident #6 had a diagnosis of depression that could cause variations in their mood. Interventions included to administer medications as ordered and arrange for psych consult and follow up as indicated. Resident #6 used psychotropic medications related to bipolar disorder with an intervention to administer medications as ordered by the physician. Review of the Order Summary Reported dated 09/15/2025, documented Resident #6 had an active order with start date of 07/31/2024 for psychiatry evaluation and consults as needed.Review of psychiatry follow up notes revealed:- on 10/04/2024 (untimed) Nurse Practitioner #3 (of psychiatry) documented they had been seeing Resident #6 and the resident continued with somatic symptoms (extreme focus on physical symptoms) most likely related to anxiety and had a differential diagnosis of hypochondriasis (excessive and unduly worried belief that one has a serious illness). They documented Resident #6 reported signs of depression, anxiety and irritability. Nurse Practitioner #3 documented Resident #6 would benefit from psychotherapy and consider placing a referral. -on 01/17/2025 at 10:30 AM, Nurse Practitioner #3 (of psychiatry) documented Resident #6 stated they had been having a lot of crying jags and the resident had displayed behaviors at times, refusing medications, and calling numerous specialty providers to make appointments. Nurse Practitioner #3 documented they recommended to consider follow-up with psychology.-on 07/21/2025 at 3:00 PM, Psychiatrist #1 documented Resident #6 stated they felt the need for more support but expressed insight into their own behaviors. Psychiatrist #1 documented they encourage supportive counseling and group therapy to build coping skills and social connection. Review of Resident #6's electronic medical record (progress notes, medical provider notes, and consultant notes) from 10/05/2024 through 09/11/2025 revealed there was no documented evidence that Resident #6 had psychotherapy/counseling services completed.During an observation and interview on 09/11/2025 at 11:19 AM Resident#6 was sleeping in bed, fully dressed and appeared well groomed. Resident #6 was easily awakened and stated they were not feeling all that well and their blood pressure was elevated. Resident #6 became anxious and was asking what was too high of a blood pressure and how high should the blood pressure be before they needed to go to the hospital.During an interview on 09/11/2025 3:05 PM, Resident #6 was self-propelling their wheelchair around the nursing station and hallways. Resident #6 stated they were not receiving any counseling service, and they would like to as they would like additional people to talk to. They stated the psychiatrist recommended for them to (continued on next page)

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	335164	A. Building B. Wing	10/10/2025

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

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	see a counselor and the facility had not yet set it up.During an interview on 09/15/25 at 9:29 AM, Social Worker #1 stated the social workers were responsible for the referral process when a resident had a recommendation to see the psychiatrist and/or psychologist at the facility. They stated they were also responsible to review the psychiatry notes. Social Worker #1 stated if there was a recommendation of psychotherapy, they would email a referral request to the service the facility used for psych services. Social Worker #1 stated Resident #6 was under psychiatric care but was not seeing the psychologist. After they reviewed their email referrals, Social Worker #1 stated they had never put in a referral request for Resident #6 to have psychotherapy but should have because it was a recommended made by the psychiatrist. They stated that they were the only social worker in the facility from about mid-February 2025 to maybe May 2025. They stated the previous social worker must have also never placed the referral for Resident #6, but the previous social worker should have also.During a telephone interview on 09/12/2025 at 11:34 AM, Psychiatrist #1 stated they knew the facility provided psychotherapy services, so they made a recommendation for Resident #6 to receive those services. They stated they expected that their recommendation would have been approved, the social work would have followed up with the recommendation, and had an appointment made. Psychiatrist #1 stated that medication could only do so much, and Resident #6 would have benefited from additional counseling or group therapy sessions. During a telephone interview on 09/15/2025 at 12:16 PM, Nurse Practitioner #1 stated they were familiar with Resident #6 and the resident was under the care of a psychiatrist. They stated they were unsure if Resident #6 was participating in psychotherapy. They stated that if the psychiatrist had recommended psychotherapy and the facility provided that service then they would expect Resident #6 to be seeing a counselor.During an interview on 09/16/25 at 9:31 AM, Registered Nurse #2 (Resident Care Coordinator of the third floor) stated they had only worked at the facility for about four (4) weeks. They stated when a recommendation for a consult was recommended, they would get an order from a medical provider and put the recommendation in the communication book for the unit sectary to obtain the consult. Registered Nurse #2 stated they believed this process was the same for psych visits. They stated they would also read any consult notes themselves to look for any recommendation. After reading the psychiatrist notes dated 10/04/2025, 01/17/2025 and 07/21/2025 they stated they expected that Resident #6 would have been receiving counseling services as recommend by whoever the facility utilized for those services. Registered Nurse #2 stated Resident #6's main behaviors consisted of fixating on their medical complaints. During an interview on 09/16/25 at 9:46 AM, the Director of Nursing #1 stated they had contacted the psych provider service the facility utilized, and Resident #6 did not participate in psychotherapy with the facility's psychologist. Director of Nursing #1 stated the facility did not and could not provide a phone number for Licensed Psychologist #1. They stated the social workers were responsible for reviewing any psychiatry notes and for placing any referrals for psychiatry and/or psychotherapy a resident might need. After they reviewed Resident #6 psychiatry notes dated 10/04/2025, 01/17/2025 and 07/21/2025, Director of Nursing #1 stated they expected that the social worker would have followed up with the psychiatry recommendations and set up a referral with the psychologist. Director of Nursing #1 stated they were very familiar with Resident #6 and the resident could have many complaints, anxiety, and their parents had a history of psychological issues. During an interview on 09/16/2025 at 12:16 PM, Director of Nursing #1 stated they could not locate any policies on psychology consultants or any policies on any type of consults.2.Resident #155 had diagnoses including frontotemporal neurocognitive disorder (brain disorder that affects personality, behavior, and language), dementia without behavioral disturbances, and adult failure to thrive. The Minimum Data Set, dated [DATE] documented Resident #155 was severely cognitively impaired, was understood, and usually understands.The Comprehensive Care Plan, initiated 11/25/2024, documented Resident #155 had impaired cognitive function or impaired though processes related to dementia. Interventions included to cue, reorient, and supervise as needed, engage in simple, structured activities that avoid overly demanding tasks, keep residents' (continued on next page)

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