STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335180	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Safire Rehabilitation of Northtowns, L L C	2799 Sheridan Drive Tonawanda, NY 14150

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview during survey, the facility failed to ensure that a resident received adequate supervision and assistive devices to prevent accidents/hazards for two (Resident #1 and Resident #2) of five residents reviewed for accidents. a.) Specifically, on 06/04/2026 Resident #1 who was severely cognitively impaired, wore a wander alert device due to being at high risk for elopement, exited the facility undetected through doors that were not secured by the wander alert system. Resident #1 was located 12 hours later approximately three miles away by local police. This resulted in no actual harm that was Immediate Jeopardy and Substandard Quality of Care with the likelihood of serious harm, serious impairment, serious injury or death to Resident #1's health and safety. b.) On 06/29/2026, Resident #2's wander alert device failed to alarm when tested.The findings include: The facility policy and procedure titled Missing Resident/Elopement Policy and Procedure Statement Prevention revised 05/21/2026 documented it is the policy of the facility to provide a safe and secure environment for all residents. The facility policy and procedure titled Accidents and Incidents-Investigating and Reporting dated 04/26/2018 documented the facility will ensure that the residents environment remains free from accident hazards as is possible while providing adequate supervision and assistive devices to prevent accidents. a. Resident #1 had diagnoses that included Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills), alcohol abuse and chronic obstructive pulmonary disease (a progressive, incurable lung condition that limits airflow). Minimum Data Set (a resident assessment tool) dated 06/08/2026 assessed Resident #1 as severe cognitive impairment. Resident #1 had no Minimum Data Set prior to the incident. The Nursing admission assessment dated [DATE] documented Resident #1 was checked for wandering, history of elopement, and exit seeking. Review of the baseline care plan dated 06/02/2026 revealed Resident #1 wore a wander alert bracelet to their right wrist and had wandering behaviors. The Nursing Progress Note dated 06/04/2026 completed by the Assistant Director of Nursing documented at 8:30 AM, they were notified by Unit Clerk #1 that Resident #1 was not in their room when breakfast was being served and instructed staff to search and called Dr. [NAME] (a search plan when a resident elopes from the facility). They notified the Director of Nursing, Administrator, Resident #1's spouse, and law enforcement. Review of the facility Incident Overview dated 06/04/2026 revealed the Administrator was made aware of the incident at 8:30 AM. The Dr. Walker procedure plan was announced, and the facility conducted an unsuccessful internal and external search. Local law enforcement and Resident #1's spouse were notified. The Nursing Progress Note dated 06/04/2026 documented that Resident #1 returned to the facility escorted by law enforcement at 6:51 PM on 06/04/2026. Review of the Police Report revealed on 06/04/2026, Resident #1 had been located at 6:10 PM approximately three miles from the facility and was returned to the facility. The Elopement/Wander Risk Assessment signed and dated 06/05/2026 by the Director of Nursing documented Resident #1 was a high risk for elopement. Review of video surveillance provided by the facility on 06/29/2026 at 9:59 AM, revealed on 06/04/2026 between 6:30 AM and 6:36 AM, Resident #1 was observed walking down the third floor west wing without any facility staff (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	present fully dressed carrying a large duffle bag and proceeded down to the elevators across the third floor nurses station, then turned away from the elevators, proceeded to the emergency exit door, read the signs posted on the door, then proceeded down the third floor east wing hallway towards a stairwell door that leads down to the first floor exit door of the building to the parking lot. The video surveillance outside of the building revealed Laundry Aide #1 pulling up, parking, and remaining in the vehicle for a few minutes while Resident #1 left the facility at approximately 6:33 AM. During a telephone interview on 06/29/2026 at 12:18 PM, Laundry Assistant #1 stated they were unfamiliar with Resident #1. People go in and out of the building from that area often. They parked and sat in their car for a few minutes on 06/04/2026 at approximately 6:30 AM and stated someone came walking by carrying a bag but they thought Resident #1 was an employee, so they did not say anything to anyone. During an interview on 06/30/2026 at 9:38 AM, the Director of Maintenance stated the third-floor east wing hallway stairwell door has a keypad and a magnetic locking system that is used to open the door. The first floor exit door to the outside near the parking lot had no alarm system to alert when the door was accessed. They stated the facility has a wander alert system but the doors the resident exited through did not have this system on them. During an interview on 06/30/2026 at 11:05 AM, Maintenance Assistant #1 stated in the past, magnets had slipped on the magnetic locked doors because the screws got old and rusty, and the doors were frequently used by staff, which could cause the magnets to slip down, disengaging the locking mechanisms on the door. They stated they were informed that the Regional Maintenance Director had been in the facility the day of the elopement and had tightened the screws on the magnetic locked doors and changed the codes. During an interview on 06/30/2026 at 11:19 AM, the Administrator stated they did not have a facility policy regarding door checks. During a follow up interview on 06/30/2026 at 12:58 PM, the Director of Maintenance stated the Regional Maintenance Director came into the facility on [DATE], but they were unaware if they tightened any screws on magnetic locks. Additionally, they stated it could be beneficial to do more frequent checks on doors, including the magnetic locks; they stated a lot can happen between one Monday to the next Monday. During an interview on 06/30/2026 at 1:37 PM, the Administrator stated after they were advised on 06/04/2026 at 8:30 AM that Resident #1 was missing, they did a second sweep of the doors and found that the three east wing hallway stairwell door was unlatched. During a telephone interview on 07/01/2026 at 11:13 AM, the Medical Director stated that Resident #1's elopement from the facility on 06/04/2026 could have been a dangerous situation. Resident #1 could have walked into the busy street or could have been hit by a car. The Medical Director stated, our job was to keep the residents safe and would expect the facility to have a policy for the magnetic lock doors. During a follow up interview on 07/01/2026 at 3:00 PM, the Administrator stated they had no knowledge of any loose magnets on any magnetic locked doors. The facility wander alert system was appropriately applied but they did not take into consideration the magnetic lock doors as those doors were used only for emergency use. At that time of Resident #1's disappearance, the magnetic lock door had yet to be identified. The main stairwell was the only stairwell that was utilized by the general staff. When they arrived at the facility on 06/04/2026 at 8:30 AM and reviewed the camera footage they determined Resident #1 had exited the building to the parking lot. They went up to the third-floor east stairwell and saw for themselves that the door was unlatched. The Survey team determined the immediacy was removed on 07/02/2026 at 5:35 PM based on the following corrective actions taken by the facility: -Upon return to the facility on [DATE], Resident #1 was placed on fifteen-minute checks with door watchers present until staff procured for 1:1 on 06/05/2026 at all times.- All exterior exit doors have been alarmed and mag locked and are functional. Keys were limited to the Director of Maintenance, the Food Service Director, Director of Nursing, the Administrator and the Nursing Supervisor.- The facility conducted daily door checks. - The facility revised the policy Prevention of Elopement and Wandering Protocol. dated 06/05/2026. - If an outside vendor is in the facility that requires unlocking of an emergency exit door, Maintenance will be with the vendor until the work is completed, and the doors have been secured. - 91.5% of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	licensed nursing staff reeducation on door security and door safety and the elopement protocol by 07/02/2026.- The facility completed a 100% audit of all residents and ensured all residents had elopement assessments and no new residents were identified as a high risk for elopement. b. Resident #2 had diagnoses that included hypertension (high blood pressure), diabetes mellitus (high blood sugar), and depression (mood disorder that causes persistent sadness and a loss of interest in activities). The Minimum Data Set, dated [DATE] documented Resident #2 was independent with chair/bed to chair transfers and wheelchair mobility and had no wandering behaviors.There was no documented evidence that the facility had a policy related to wander alert system testing or testing resident wander alert devices for functionality. Review of the undated facility wander alert list verified as the current list of wanderers, provided by the Administrator on 06/29/2026, displayed a photograph of Resident #2 indicating they were a wanderer. During an observation and interview on 06/29/2026 at 11:25 AM, Unit Clerk #1 wheeled Resident #2 to the third-floor elevator and when the elevator door opened, they wheeled Resident #2 in their wheelchair onto the elevator. The wander alert device did not alarm. Unit Clerk #1 stated at that time, the alarm should have sounded, and the elevator should not move until a code is typed on the keypad but for some reason it did not work. Then Unit Clerk #1 notified the Assistant Director of Nursing. During an observation on 06/29/2026 at 11:47AM, the Assistant Director of Nursing replaced Resident #2's wander alert bracelet with a new wander alert bracelet, activated the bracelet with the detector box and then wheeled them onto the elevator. The wander alert system sounded. During an interview on 06/29/2026 at 12:45 PM, the Assistant Director of Nursing stated they replaced Resident #2's wander alert bracelet as the detector box they held next to the old bracelet indicated that the battery was no good. The Assistant Director of Nursing did not know how long the battery was dead. They were unaware of the process for checking the functionality of the wander alert bracelets. The staff would have knowledge of when the batteries were nonfunctioning because the alarm would not sound when they were brought onto the elevator. During an interview on 06/29/2026 at 12:49 PM, Maintenance Assistant #1 stated they did wander alert system checks monthly by going around with a wander alert bracelet to make sure the doors were activated but they had no documented evidence of doing such. They stated they did not ensure the wander alert bracelets were functioning as it was nursing's responsibility. During an interview on 06/29/2026 at 1:31 PM, the Director of Nursing stated they stopped doing checks for the wander device system when the new system was implemented two years ago. During an interview on 06/30/2026 at 9:37 AM, the Director of Maintenance stated they could not find a policy for the wander alert system. They stated they contacted the manufacturer today for the manufacturer guidelines for the new wander alert system. They stated a policy for the wander alert system would be beneficial as there would probably be more stuff to look for. They further stated the wander alert system is monitored by the receptionist at the front desk between 8:00 AM and 8:00 PM and was unsure who monitors the system between 8:00 PM and 8:00 AM. Further, at approximately 3:00 PM, the Director of Maintenance provided the surveyor with a printout of the guidance which they received via e-mail. During an interview on 06/30/2026 at 11:19 AM, the Administrator stated they were calling the manufacturer of the new wander alert system today to get the manufacturers guidelines for the system; they stated they did not have a facility policy regarding the wander alert system. Review of the wander alert quick reference guide dated 2023 revealed the battery life could be tested by the detector and recommended that the wander alert detector be used weekly to test the bracelet battery. Shelf life from the manufacturing date was eight months. Review of the wander alert wearable bracelet user sheet revealed weekly testing and maintenance of this product, as described in the product documentation is essential to verify the system is operating correctly and to ensure that the probability of detecting an alarm and/or locating the transmitter are maximized. The failure to undertake regular testing and maintenance will increase the risk of system failure to detect resident wandering. The failure to undertake testing and maintenance will increase the risk of false reports of resident wandering. During a telephone interview on 07/01/2026 at 11:13 AM, the Medical Director (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated they would expect the facility to have a policy on the current wander guard system. It would be much smoother if everyone knew what the process was and to keep the residents safe. During an interview on 07/01/2026 at 11:30 AM, Registered Nurse #3 Unit Manager stated to check the wander alert bracelets they would walk every resident to the elevator because it was easier than going to get the detector to see if it set the alarm off and ensured the bracelets functioned. They stated they had no documentation that this was being done. During an interview on 07/01/2026 at 11:41 AM, the Administrator stated they abated the process of checking and signing off on the functionality of the wander alert bracelets when they implemented the new system eleven months ago. There were no sheets for the supervisors to physically check off for the wander alert bracelets. The Administrator stated the system monitored the functionality of the wander alert bracelets and that an alert would be displayed with a low battery indicator on the monitor at reception if one of the batteries needed to be changed. The Administrator stated the staff from Unit One were expected to monitor the wander guard alert device in the absence of the receptionist and to run to the reception desk and check the location of where the alarm was coming from. There was no policy on the current wander guard system. New York Code Rules and Regulations 415.12(h)(1)(2)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during survey, 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 administration failed to ensure a safe environment for cognitively impaired residents who wander and/or are at risk for elopement. a.) Specifically, Resident #1 was located 12 hours later approximately three miles away by local police on 06/04/2026. b.) On 06/29/2026, Resident #2's wander alert device failed to alarm when tested and the facility had no policy, current manufacturers guidance or system that monitored the functionality of the wander alert bracelets weekly per the manufacturers' recommendations. This has the potential to affect seven residents identified as at risk of unsafe wandering and at risk of elopement.The findings include: The facility policy and procedure titled Missing Resident/Elopement Policy and Procedure Statement Prevention revised 05/21/2026 documented it is the policy of the facility to provide a safe and secure environment for all residents. REFER TO: F 689 - Free from Accident Hazards/Supervision/Devices, Scope and Severity J a. Resident #1 had diagnoses that included Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills), alcohol abuse and chronic obstructive pulmonary disease (a progressive, incurable lung condition that limits airflow). Minimum Data Set (a resident assessment tool) dated 06/08/2026 assessed Resident #1 as severe cognitive impairment. During an interview on 06/29/2026 at 2:10 PM, Maintenance Assistant #1 stated that the maglock must have slipped and disengaged the magnet from the third floor east exit door and it caused the door to inactivate causing the alarm to not sound when someone entered through it and assumed that's how Resident #1 got out. During an interview on 06/30/2026 at 9:38 AM, the Director of Maintenance stated the third-floor east wing hallway stairwell door has a keypad and a magnetic locking system that is used to open the door. The first floor exit door to the outside near the parking lot had no alarm system to alert when the door was accessed. They stated the facility has a wander alert system, but the doors Resident #1 had exited though they did not have this system on them. The Director of Maintenance stated they were not made aware of any magnets slipping on doors on 06/04/2026 and were unaware if a magnet was fixed on any doors in the facility on that day. They stated if a magnet were to slip (slide down) on a mag locked door, the door would not be locked; the locking mechanism would not be engaged. The Director of Maintenance stated if the magnet was found to be slipping, they should have been made aware by staff; It would have helped them ensure that there were no longer elopement concerns or the safety of residents. During a telephone interview on 07/01/2026 at 11:13 AM the Medical Director stated they would expect the facility to have a policy for the magnetic lock doors. The Director of Maintenance stated they were not made aware of any magnets slipping on doors on 06/04/2026 and were unaware if a magnet was fixed on any doors in the facility on that day. They stated if a magnet were to slip (slide down) on a mag locked door, the door would not be locked; the locking mechanism would not be engaged. The Director of Maintenance stated if the magnet was found to be slipping, they should have been made aware by staff; It would have helped them ensure that there were no longer elopement concerns or the safety of residents. During an interview on 07/01/2026 at 3:00 PM the Administrator stated the main stairwell was the only stairwell that was utilized by the general staff. When they arrived at the facility on 06/04/2026 at 8:30 AM and reviewed the camera footage they determined Resident #1 had exited the building to the parking lot. They went up to the third-floor east stairwell and saw for themselves that the door was unlatched. There was no system for checking the doors prior to the incident. The Administrator stated they had no knowledge of any loose magnets on any mag locked doors. The facility systems were appropriately applied but they did not take into consideration the mag lock doors as those doors were used only for emergency use. At that time of Resident #1's disappearance the mag lock door had yet to be identified. Evaluation of all the non-mag (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	locked doors were reviewed after the incident during Quality Assurance and Performance Improvement with recommendations made to mag lock other doors located in the emergency stairwells. The intermittent unsecured mag lock door allowed Resident #1 to leave undetected. b. Resident #2 had diagnoses that included hypertension (high blood pressure), diabetes mellitus (high blood sugar), and depression (mood disorder that causes persistent sadness and a loss of interest in activities). The Minimum Data Set, dated [DATE] documented Resident #2 was independent with chair/bed to chair transfers and wheelchair mobility and had no wandering behaviors. During an interview on 06/29/2026 at 12:45 PM, the Assistant Director of Nursing stated they were unaware of the process for checking the functionality of the wander alert bracelets. During an interview on 06/29/2026 at 1:31 PM, the Director of Nursing stated there was no documented evidence that the facility had a policy related to wander alert system testing or testing resident wander alert devices for functionality. During an interview on 06/30/2026 at 9:37 AM, the Director of Maintenance stated they could not find a policy for the wander alert system. They stated they contacted the manufacturer today for the manufacturer guidelines for the new wander alert system. They stated a policy for the wander alert system would be beneficial as there would probably be more stuff to look for. Further, at approximately 3:00 PM, the Director of Maintenance provided the surveyor with a printout of manufacturer guidance which the Director of Maintenance received via e-mail. During a telephone interview on 07/01/2026 at 11:13 AM, the Medical Director stated they would expect the facility to have a policy on the current wander guard system. During an interview on 07/01/2026 at 11:41 AM, the Administrator stated they assumed the wander alert system monitored the functionally of the bracelets. There was no policy on the current wander guard system. 10 New York Code Rules Regulations 415.26