STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335534	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salamanca Rehabilitation & Nursing Center	451 Broad Street Salamanca, NY 14779

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during a complaint investigation (NY00370043- 694884) completed during the standard survey completed on 12/05/2025, the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than two (2) hours after the allegation was made, to the administrator and to the state survey agency for two (2) (Residents #10 and #120) of three (3) residents reviewed. Specifically, facility staff did not report alleged sexual abuse to the administrator immediately which resulted in not reporting to the state survey agency within the required time frames.The findings are:The policy titled Abuse- Investigation, Protection and Reporting, dated 10/24/2022, documented that abuse will be thoroughly investigated and promptly reported to local, state and federal agencies. All reports of an alleged violation of abuse will be reported immediately, but not later than (2) two hours after the allegation.Resident #10 had diagnoses including Wernicke's encephalopathy (a severe brain disorder caused from lack of thiamine, causing confusion, unsteady walking, and vision issues), history of alcohol abuse and generalized anxiety. The Minimum Data Set, dated [DATE] documented they were severely cognitively impaired, usually understood and usually understands others. Resident #10 was independent with mobility and required partial/moderate assistance from staff for dressing.The comprehensive care plan dated 07/22/2020 documented Resident #10 had a self-care performance deficit related to a history of alcohol abuse. They were independent for mobility but required limited assistance from one (1) staff for lower body dressing. They had impaired cognitive function related to dementia and staff should ask yes or no questions.Resident #120 had diagnoses including dementia, chronic obstructive pulmonary disease (lung disease that makes it difficult to breath), and heart failure. The Minimum Data Set, dated [DATE] documented Resident #120 was cognitively intact, always understood and always understands others, and were independent with mobility.The comprehensive care plan dated 01/01/2025 documented a behavior problem of making exaggerated, off-colored, provocative statements to elicit reactions from staff. Also embellishes stories for comedic effect, staff were to reinforce why the behavior was inappropriate and educate that making jokes about events could lead to consequences.The facility Investigation, completed on 01/31/2025, included staff and resident interviews . The investigation documented on 01/26/2025 Certified Nurse Aide #1 reported the allegation of sexual abuse, that occurred on 01/24/2025, to Registered Nurse #3. Registered Nurse #3 reported the incident to the Director of Nursing immediately and assessed both residents. The investigation revealed Certified Nurse Aide #1 stated, while doing rounds, they knocked on Resident #10's doorframe and entered the room. The room was dark with the TV on, they thought they saw Resident #10 lying flat on the bed with their pants down and Resident #120 laying on their side, fully clothed, with their back to the door and their head near Resident #10's pelvic area. They were uncomfortable so they left the room to get another certified nurse aide to help get Resident #120 out of the room. When they returned with another certified nurse aide, both residents were fully clothed and sitting upright on the bed. Neither resident appeared distressed. The two residents were close friends, but staff had never witnessed anything sexual prior to the incident. Resident #10 denied (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything inappropriate occurred. Resident #120 initially made comments about inappropriate behavior but then immediately changed their story. When the staff made them leave the room, they stated that you people can't take a joke, nothing happened.Review of Resident #10's progress notes dated 01/24/2025-1/25/2025 revealed there was no documented evidence of alleged sexual abuse with Resident #120.Resident #120's progress notes dated 01/24/2025 - 01/25/2025 revealed there was no documented evidence of alleged sexual abuse with Resident #10.The 24-Hour Nursing Services Reports dated 01/24/2025 - 01/25/2025 did not document the alleged abuse between Resident #10 and Resident #120. The 24-hour report sheet dated 01/26/2025 documented that Resident #10 and Resident #120 were not allowed in rooms alone- use public space for visits.During an interview on 12/02/2025 at 12:00 PM, Resident #120 stated they did have a friendship with Resident #10, but they had never had any sexual contact with them. They went down to sit in the hall with them occasionally.During an interview on 12/03/2025 at 9:43 AM, Resident #10 stated they did not recall an incident with Resident #120. They did not recall having a friendship with Resident #120. They did recall that they were not allowed to have female residents in their room. Resident #10 stated they had never been intimate with anyone in the facility.During a telephone interview on 12/04/2025 at 1:00 PM, Certified Nurse Aide #1 stated they were not really sure what they saw on 01/24/2025. They recalled they knocked and walked into Resident #10's room. It was dark, with just the TV on. At the time they thought they saw Resident #10 laying on their back with their pants down and Resident #120 laying on their side, with their head near Resident 10's groin. Their back was to the door. Neither resident was moving. They felt uncomfortable with what they saw so they stepped back out of the room and went to tell Licensed Practical Nurse #1 and get help from Certified Nurse Aide #2. Licensed Practical Nurse #1 did not really respond to what they told them, they did not know if they reported it to the supervisor at that time. Within a few minutes, Certified Nurse Aide #1 & Certified Nurse Aide #2 went into Resident #10's room. When they entered the room both residents were fully clothed and sitting on opposite sides of the bed. Resident #120 was escorted out of Resident #10's room. Certified Nurse Aide #1 stated they were talking about what they thought they saw to another staff member when the supervisor overheard them, on 01/26/2025, and that was when they changed their care plans to not allow them in each other's rooms.12/04/2025 at 10:53 AM, a telephone interview was attempted with Certified Nurse Aide #2 without success.12/04/2025 at 10:54 AM a telephone interview was attempted with Licensed Practical Nurse #1 without success.12/04/2025 at 11:00 AM a telephone interview was attempted with Registered Nurse #3 without success.During an interview on 12/04/2025 at 11:40 AM, the Assistant Director of Nursing (previous unit coordinator on 1 WEST) stated they were made aware of the alleged incident on Monday 01/27/2025 during morning report. They stated Licensed Practical Nurse #1 should have reported the allegation to the supervisor immediately and they would have called the Director of Nursing to start the investigation. During an interview on 12/05/2025 at 9:59 AM, Registered Nurse #1 stated they were the supervisor on the evening of 01/24/2025. They stated they were not notified of any alleged inappropriate behavior between Resident #10 and Resident #120. Registered Nurse #1 stated that they would have immediately notified the Director of Nursing so the allegation could have been investigated and reported to the state. Registered Nurse #1 stated allegations of abuse should be reported within two (2) hours.During an interview on 12/05/2025 at 10:07 AM, the Director of Nursing stated they expected all staff to report inappropriate behavior between residents immediately. They were educated on abuse reporting when they were hired and at least annually. They were notified by Registered Nurse #3 on 01/26/2025, they started the investigation and reported the allegation to the state. The Director of Nursing stated Licensed Practical Nurse #1 should have reported the allegation to the supervisor immediately.During an interview on 12/05/2025 at 10:24 AM, the Administrator stated they expected their staff to report any allegations of abuse immediately. Certified nurse aides should report to the nurse, and the nurse should report to the supervisor. They were made aware of the allegation on 01/26/2025 by the Director of Nursing who reported it to the state. The (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated allegations of abuse should have been reported immediately because they only had two (2) hours to report it to the state.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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record review conducted during a Standard Survey completed on 12/05/2025, the facility did not ensure that each resident who was unable to carry out Activities of Daily Living received the necessary services to maintain grooming and personal hygiene for 1 (one) (Resident #8) of five (5) residents who were reviewed for activities of daily living. Specifically, Resident #8 who was dependent on staff for all Activities of Daily Living was not provided with timely incontinent care. Additionally, infection control practices were not maintained during care.The finding is:The policy and procedure titled Toileting, dated 03/07/2022 documented it is the policy of the facility to provide all residents with timely, person centered assistance for toileting that maintain dignity, promotes independence, and supports continence to the greatest extent possible. Residents are to be assessed for voiding patterns and care planned appropriately. Timely Response: answer call lights promptly, anticipate needs at predictable times (e.g., wake-up, after meals, bedtime). Based on intervals on diary (e.g., every 2-4 hours). Infection prevention: Hand hygiene before and after toilet assist. Cleanse gently after episodes of incontinence. Appropriate use of gloves and PPE, clean disinfect toilet equipment and surfaces per protocol.Resident #8 had diagnoses of hemiplegia (paralysis of one side of the body) multiple sclerosis (an autoimmune disease of the central nervous system), diabetes mellitus, and osteomyelitis (an infection of the bone). The Minimum Data Set (a resident assessment tool) dated 07/04/2025 documented the resident was severely cognitively impaired, sometimes understands and was sometimes understood by others. The Minimum Data Set documented the resident was non-ambulatory, required total dependence on staff for toileting and hygiene; and was always incontinent of bowel and bladder.The Comprehensive Care Plan dated 07/03/2025 documented Resident #8 had bowel and bladder incontinence related to impaired mobility. Interventions included but not limited to, were to use disposable briefs, change as needed, clean peri area with each incontinence's episode.Review of a Kardex (a guide used by staff to provide care) dated 10/01/2025 documented to maintain enhanced Barrier precautions at all times, clean peri area with each incontinence episode, resident uses disposable briefs, change resident as needed. Resident #8 was a total assist of two staff members.During a continual observation on 09/30/2025 from 9:04 AM - 11:00 AM Resident #8 was seated in a Geri chair in their room near the nurse's station. The resident repeatedly called out for assistance with incontinence care. Staff did not respond.At 11:21 AM Certified Nurse Aide # 5 entered the resident's room. Resident #8 was saturated with urine, and their clothes were visibly wet.During an interview on 09/30/2025 at 11:55 AM, Certified Nurse Aide #5 stated Resident #8 was a heavy wetter and that was why they were so wet.Observation on 10/01/2025 at 11:21 AM Resident #8 called out they needed to be changed.During an observation on 10/01/2025 at 11:28 AM Certified Nurse Aide #5 and Certified Nursing Aide #6 entered Resident #8 room and mechanically lifted the resident into their bed. Resident #8 was saturated with urine. The resident's clothing and chair cushion were visibly wet; and a puddle of urine was noted on floor beneath the resident. Staff completed incontinent care, without changing their gloves Certified Nurse Aide #5 handled the residents' oxygen tubing and resident's personal items.During an interview on 10/01/2025 at 11:04 AM, Resident #8 stated they were wet, and they did not feel clean. Resident #8's stated they did not press their call bell because it does not do any good so they would have to call out. They stated there was enough staff, but they would ignore them.During an interview on 10/01/2025 at 11:48 AM, Certified Nurse Aide #5 stated residents were to be changed every two hours and/or as needed. They stated Resident #8 was a part of their rounds that morning, but when they went to check on resident earlier, they were tired so decided to come back later. They stated a lapse in glove change after peri-care created infection risks when the oxygen tubing was touched with dirty gloves. They stated Resident #8 should have been checked and changed earlier. That would have avoided the resident being saturated with urine through their brief, clothing, chair cushion and onto the floor.During an interview on 10/01/2025 at 11:55 AM, Certified Nurse Aide #6 stated Certified (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Aide #5 forgot to change their gloves after incontinent and peri-care and could have caused cross contamination when they touched Resident #8's oxygen tubing. They stated residents were to be changed every two hours per facility policy and as needed. They stated that this was important to make sure the resident skin did not breakdown. They stated Resident #8 was a heavy wetter but felt that the resident must have waited over two hours by evidence of the puddle of urine on the floor and saturated brief, pants and wheelchair cushion.During an interview on 12/05/2025 at 8:55 AM, Certified Nursing Aide #4 stated the policy for incontinent care was to check residents every two hours or as needed. They stated it was unacceptable for a resident to have their wheelchair and clothing soaked with urine.During an interview on 12/05/2025 at 9:48 AM, Licensed Practical Nurse #2 Supervisor, stated the certified nurse aides were to physically check residents for incontinence every two hours. They stated this was important to maintain skin from breakdown, for residents' dignity, and their general wellbeing. They stated Certified Nurse Aide #5 should have changed their gloves after incontinent care and after performing peri care due to infection control measures.During an interview on 12/05/2025 at 10:22 AM PM, the Director of Nursing stated their expectation was for staff to address residents that were calling out right away. They stated staff were to make their rounds for incontinent care every two to four hours. They stated their expectation would be for the staff to look on the Kardex to see how frequently incontinent care was to be performed, since it varied resident to resident. They stated no resident should be left in urine-soaked clothing, wheelchair cushions, or have urine puddles on their floor. They stated when the Certified Nursing Aide #5 completed Resident #8's peri care they should had changed their gloves to reduce the risk of cross contamination. They stated Certified Nursing Aide #5 should have not touched the tubing with the dirty gloves and Certified Nursing Aide #6 should have stopped them immediately, corrected them, and told them to get a new nasal canal and replace it. 10 NYCRR 415.12 (a) (3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review during a Standard Survey completed on 12/05/2025, the facility did not ensure that all residents remained free of accident hazards as is possible, and each resident received adequate supervision to prevent accidents for one (1) (Resident #19) of five (5) residents observed for accidents. Specifically, the facility did not identify a potential hazard that Resident #19 had an e-cigarette/vape device stored in their room. Additionally, there was no order for use of an e-cigarette/vape, no care plan interventions for its use, and no assessment by the interdisciplinary team to ensure safe storage of the device. The finding is:The policy titled Resident Safety and Accident Prevention dated 03/2025, documented the facility is committed to providing a safe and supportive environment for all residents by implementing a structured, proactive accident prevention program. The program focuses on identifying and addressing both individual and environmental factors that could contribute to resident injury or illness. The facility routinely evaluates all resident accessible areas for potential hazards and promptly implements corrective actions as necessary to reduce risk. Residents and or their designated representatives will be educated on identified risks, expectations for safe behavior and any interactions in place.The policy titled Smoking Policy dated 10/23/2025, documented the facility protects the rights and safety of the residents, staff members and visitors, and a restricted smoking policy has been adopted by the facility. Smoking (including e-cigarettes) is forbidden in all indoor and outdoor areas of the facility for residents. Residents will be educated upon admission regarding the facility smoking policy. All residents that express a desire to smoke will have smoking assessment completed to determine their safety and physical ability to smoke. Smoking privileges will be granted based on the smoking assessment. Residents who are determined to be safe to smoke independently, will be required to surrender all smoking materials to staff. They must be able to go outside of facility property to smoke.Resident #19 had diagnoses of chronic obstructive pulmonary disease (lung and airway disease that restricts breathing), type 2 diabetes mellitus, and bipolar disorder (a brain disorder causing extreme shifts in mood, energy and activity levels). The Minimum Data Set (a resident assessment tool) dated 09/26/2025, documented that Resident #19 was cognitively intact, able to understand others and could be understood by others. Resident #19 had no upper or lower extremity impairments, utilized a walker and wheelchair for mobility, was independent with all activities of daily living, and had no behavioral issues.Review of a Comprehensive Care Plan dated 10/06/2025, documented Resident #19 was able to smoke while out of the facility on pass. Interventions included cigarettes and lighter must be kept in a secure place with the nurse, the resident may sign themselves out of the facility daily to smoke off the property, educate the resident on the effects of smoking verses nonsmoking, and offer other options to refrain from smoking. Resident #19 was at risk for actual falls due to history of falls and interventions included safety monitoring at the beginning and end of the shift and with all rounds every shift. There were no interventions regarding the use of an e-cigarette/vape device.Review of a Kardex (a guide used by staff to provide care) dated 12/05/2025, documented Resident #19 preferred eating meals in their room, resident preferred to have several items on their bed at all times, and refused to declutter their room and bed area. The Kardex did not address the use of an e-cigarette/vape device.Review of a Smoking and Safety assessment dated [DATE], documented Resident #19 was assessed for smoking and safety with the use of tobacco products. Resident #19 safely demonstrated ability to use lighter, hold cigarette and extinguish appropriately. Resident #19 was independently safe to smoke outside of the facility. The assessment did not include use of an e-cigarette/vape or that the resident knew where smoking materials were supposed to be stored. During an observation on 12/03/2025 at 12:03 PM, Resident #19 was in bed resting. There were two brown bags full of snacks on the floor and one brown bag full (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of garbage. Resident had many items on their tray table and on their bed.During an observation and interview on 12/04/2025 at 11:48 AM, Resident#19 was lying in bed, they moved their blanket partially off them exposing an e-cigarette on the mattress, next to them. Resident #19 immediately tried to cover it back up with the blanket. They stated their family member took them to the store around Thanksgiving and they purchased it then. They stated they did not know they were not allowed to have it in their room. They stated they did not smoke in the facility only when out on pass. During an interview on 12/04/2025 at 11:50 AM, Licensed Practical Nursing Supervisor #2 stated they were unaware that Resident #19 had an e-cigarette and would address the issue right away.During an interview on 12/04/2025 at 11:52 AM with Licensed Practical Nursing Supervisor #2 they stated they retrieved the e-cigarette/vape from Resident #19, secured it in a safe location, educated resident, notified administration and attempted to contact residents' health care proxy. They stated the resident would be able to ask for it when they went out on pass and would have to give back to the nurse when they returned. They stated Resident #19 told them they go out on pass three times a week for lunch and only smoked their e-cigarette then.During an interview on 12/04/2025 at 1:15 PM with Certified Nursing Aide #7 they stated they never witnessed Resident #19 with an e-cigarette but if they did, they would report it to the nurse and let them handle it. They stated this was important because e-cigarettes could be dangerous in the hands of the wrong person.During an interview at 12/05/2025 at 9:33 AM, with Licensed Practical Nursing Supervisor #2 they stated Resident #19 had not had any cigarettes in the facility for months, but when they did, they would retrieve them from the nursing station and were always compliant with being 100 feet away from the building when they smoked. They stated the resident was compliant with giving them to staff to secure in a safe place. They stated when their family member would bring a new pack in, they would always bring them to the desk to be stored safely. During an interview on 12/05/2025 at 10:17 AM, Certified Nursing Aide #4 stated they had never witnessed Resident #19 using an e-cigarette or vape in their room. They stated if they did, they would make the resident aware they could not have that in their room and notify their supervisor.During an interview on 12/05/2025 at 10:18 AM with Certified Nursing Aide #8 they stated they never saw Resident #19 smoke an e-cigarette/ vape in their room. They stated if they did, they would notify the supervisor because it could be a fire hazard. During an interview 12/05/2025 at 10:25 AM with the Director of Rehab, they stated the assessment for an e-cigarette or vape would be the same assessment for a regular cigarette because it would require no additional dexterity (performing tasks with the hands). They stated Resident #19 was independent and would have the dexterity to utilize a lighter and an e-cigarette/vape. They stated Resident #19 was assessed as independently safe to smoke outside of the facility quarterly and they were never alerted the resident no longer utilized cigarettes. During an interview on 12/05/2025 at 10:30 AM with the Director of Nursing and the Administrator, they both stated Resident #19 knew they were not supposed to have the e-cigarette in their room and must have hidden it from staff. They stated if a staff member observed any smoking devices, they should notify their supervisor immediately and the items should be stored at the nursing station. They stated Resident #19, and their health care proxy were educated on this when the facility became non-smoking years ago. They stated all residents were educated on the smoking policy when admitted and this information was available in the welcome packet for new admissions. They stated when the policy for smoking went from a smoking facility to a non-smoking facility, Resident #19 was grandfathered in and was re-educated on when and where they could smoke moving forward. Resident #19 was compliant with all aspects of the smoking policy prior to this incident.10 NYCRR 415.12(h)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review conducted during a Standard survey completed 12/05/2025, the facility did not store all drugs and biologicals in locked compartments for one (1) unit (2 West) of three (3) units reviewed for medication storage. Specifically, medications for Resident #21 were left unattended and unsecured on an over the bed table in their room. The finding is: The policy titled Self-Administer of Medications reviewed 03/2025 documented staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration. Resident #21 had diagnoses including hypertension (high blood pressure), congestive heart failure (a chronic condition where the heart is too weak to pump blood), and anxiety disorder. The Minimum Data Set (resident assessment tool) dated 09/05/2025 documented Resident #21 was understood, understands and was cognitively intact. The comprehensive care plan dated 05/09/2025 documented Resident #21 would make choices as able. The care plan lacked documented evidence that Resident #21 had the ability to self-administer any medications. Review of the Medication Review Report dated 10/01/2025 revealed there was no physician's order for Resident #21 to self-administer the medication or to leave medications at the bedside. Review of the Self-Administration of Medication form dated 12/18/2024 documented Resident #21 was not approved for self-administration of medications and may not keep medications at their bedside. During an observation on 09/29/2025 at 11:14 AM, Resident #21 was not in their room. There was a medication bottle that was approximately half filled and labeled Gas-X Total Relief simethicone/calcium carbonate, a nasal spray bottle labeled Mucinex Sinus-Max, a nasal spray bottle labeled allergy-flo nasal spray, and a bottle of pain-relieving liquid 4% lidocaine on their over the bed table in their room.During an observation and interview on 09/30/2025 at 10:36 AM, the same medications were on Resident #21's over the bed table. Resident #21 stated they were allowed to have the medications, and they think that the ones they had in their room were on their medication list at the facility.During an observation and interview on 10/01/2025 at 10:50 AM, with Licensed Practical Nurse #4 present, the same medications were on Resident #21's over the bed table in their room. Licensed Practical Nurse #4 stated the medications should not have been in Resident #21's room. They stated that the medications should have been brought to their attention sooner and removed from the room. They were unsure if Resident #21 had orders for any of the medications and they would have to check.During an interview on 10/01/2025 at 10:52 AM, the Assistant Director of Nursing stated all of the medications that were found needed to be removed immediately. The Assistant Director of Nursing reviewed the medication list in Resident #21's electronic medical record and stated Resident #21 had an order for simethicone but it was not ordered to keep the medication at the bedside or to self-administer. The Assistant Director of Nursing stated there was no order for lidocaine, Mucinex nasal spray, or allergy-flo nasal spray. The Assistant Director of Nursing stated the medications were all sitting in the open and any staff member who had been in the room should have been able to see them. The medications at the bedside should have been brought to their attention sooner.During an interview on 10/01/2025 at 11:07 AM, Certified Nurse Aide #4 stated they had seen the medications on Resident #21's on the over the bed tray table in their room for a couple weeks. They stated they did not realize that they should have brought it to the nurse's attention.During an interview on 12/04/2025 at 10:40 AM, Nurse Practitioner #1 stated they would never expect that volume of over the counter medications in Resident #21's room. Nurse Practitioner #1 stated it would have been common sense for anybody who had seen the medications at Resident #21's bedside to bring it to the nurse's attention and notify Nurse Practitioner #1. They stated they needed to know what Resident #21 was taking to make sure there were no interactions between the medications.During an interview on 12/04/2025 at 12:58 PM, Registered Nurse #1 Resident Care Coordinator stated the only residents who should have medications at their bedside would have been (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335534	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salamanca Rehabilitation & Nursing Center	451 Broad Street Salamanca, NY 14779

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed to self-administer medications and have an order to keep the medication at their bedside to self-administer. Registered Nurse #1 Resident Care Coordinator stated their expectation of the certified nurse aides was to report any medications that were found in a resident's room to the nurse, resident care coordinator, or nursing supervisor. They stated it was important for staff to communicate any medications found in a resident room because then education would be provided to the resident or their family.During an interview on 12/05/2025 at 8:46 AM, the Director of Nursing stated there should never have been any medications left at any of the residents' bedsides unless it was approved. The stated it was expected that residents who wanted to self-administer medications to be assessed by nursing and by the nurse practitioner and there needed to be an order in place. The Director of Nursing stated, Certified Nurse Aide #4 should have let either the nurse on the medication cart, the resident care coordinator, or the nursing supervisor know about the medications in Resident #21's room.10 NYCRR 415.18(e)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review during the Standard survey completed on 12/05/2025, 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, five (5) employees (Certified Nursing Assistant #10, Housekeeper#1, Certified Nursing Assistant #11, Licensed Practical Nurse #5, and Certified Nursing Assistant #12) of ten (10) employees that were subject to the New York State Nurse Aide Registry Verification, were not reviewed through the New York State Nurse Aide Registry prior to their employment as required.The findings are:The policy and procedure titled Registry For Nurse Aides dated 01/17/2025 documented all certified nurse aides applying for a nurse aide position must present the Human Resources Director, or other designee, a copy of his/ her registration number. The Human Resources Director, or other designee, is responsible for contacting the State Nurse Aide Registry to determine the validity of the individual's certification status upon hire.1a. Review of Certified Nursing Assistant #10's personnel file revealed the employee was hired on 06/10/2025 and the file contained a New York State Nurse Aide Registry Verification Report for the employee dated 08/19/2025.Review of the electronic timecard information provided by the facility revealed Certified Nursing Assistant #10 had worked in the facility for 35 days from 06/16/2025 through 08/18/2025.During an interview on 09/30/2025 at 1:50 PM, the Human Resources Director stated Certified Nursing Assistant #10 was hired on 06/10/2025 to be a Resident Assistant and now the employee was a Certified Nursing Assistant. The Human Resources Director further stated the New York State Nurse Aide Registry Verification Report dated 08/19/2025 was the only report the facility had for the employee. 1b. Review of Housekeeper #1's personnel file revealed the employee was hired on 06/24/2025 and the file contained a New York State Nurse Aide Registry Verification Report for the employee dated 08/19/2025.Review of the electronic timecard information provided by the facility revealed Housekeeper #1 had worked in the facility for 37 days from 06/24/2025 through 08/18/2025.During an interview on 09/30/2025 at 1:56 PM, the Human Resources Director stated Housekeeper #1's was hired on 06/24/2025 to be a Housekeeper. The Human Resources Director further stated the New York State Nurse Aide Registry Verification Report dated 08/19/2025 was the only report the facility had for the employee.1c. Review of Certified Nursing Assistant #11's personnel file revealed the employee was hired on 09/15/2025 and the file contained a New York State Nurse Aide Registry Verification Report for the employee dated 09/29/2025.Review of the electronic timecard information provided by the facility revealed Certified Nursing Assistant #11 had worked in the facility for four (4) days from 09/15/2025 through 09/25/2025.During an interview on 09/30/2025 at 2:02 PM, the Human Resources Director stated Certified Nursing Assistant #11 was hired on 09/15/2025 to be a Certified Nursing Assistant. The Human Resources Director stated the New York State Nurse Aide Registry Verification Report dated 09/29/2025 was the only report the facility had for the employee.1d. Review of Licensed Practical Nurse #5's personnel file revealed the employee was hired on 08/15/2025 as an agency Licensed Practical Nurse and the file contained a New York State Nurse Aide Registry Verification Report for the employee dated 09/29/2025.Review of the electronic timecard information provided by the facility revealed Licensed Practical Nurse #5's had worked in the facility for nine (9) days from 08/15/2025 through 09/29/2025.During an interview on 09/30/2025 at 2:13 PM, the Human Resources Director stated Licensed Practical Nurse #5 was hired on 08/15/2025 to be a Licensed Practical Nurse and the employee was an agency Licensed Practical Nurse. The Human Resources Director further stated the New York State Nurse Aide Registry Verification Reports dated 09/29/2025 was the only report the facility had for the employee. 1e. Review of Certified Nursing Assistant #12's personnel file revealed the employee was hired on 10/01/2024 and the file contained a New York State Nurse Aide Registry Verification Report for the employee dated 01/16/2025.Review of the electronic timecard information provided by the facility revealed Certified Nursing Assistant (continued on next page)

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	#12 had worked in the facility for 70 days from 10/01/2024 through 01/16/2025.During an interview on 09/30/2025 at 2:49 PM, the Human Resources Director stated Certified Nursing Assistant #12 was hired on 10/01/2024 to be a Certified Nursing Assistant. The Human Resources Director further stated the New York State Nurse Aide Registry Verification Report dated 01/16/2025 was the only report the facility had for the employee.During an interview on 09/30/2025 at 3:00 PM, the Human Resources Director stated that New York State Nurse Aide Registry Verification Reports were conducted on all employees and that the reports were usually completed prior to an employee being hired at the facility. The Human Resources Director further stated they were not sure why the New York State Nurse Aide Registry Verification reports were not completed for the employees prior to the employees being hired.10 NYCRR 415.4(b)