

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Lockport Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 Lincoln Ave Lockport, NY 14094	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during a survey, the facility did make prompt efforts to resolve grievances for two (2) (Residents #5 and #6) of two (2) residents reviewed for missing property. Specifically, there was lack of follow-through and resolution for Resident #5 and Resident #6's reports of missing property. The findings are: The policy titled Resident Personal Property and Inventory, last reviewed on 08/04/2025 and approved by the Administrator 1/26 documented the facility shall maintain a system to inventory, label, and safeguard resident property to minimize the risk of loss, theft, or damage. In the event of lost property, a grievance form must be completed; the Administrator or designee will investigate the loss; if the facility is found to be responsible, the facility will replace the item or reimburse the resident for the fair market value. The policy titled Reporting and Investigation of Personal Property Lost or Damaged revised 01/26, documented the purpose was to assure that all reasonable efforts have been made to account for the location and/or condition of a resident's personal property. The individual first aware of a missing item is responsible to ensure initiation of investigation and prepare the Personal Property Loss/Damage Report is completed. The policy titled Grievance Policy revised 01/26, documented in accordance with Resident Rights residents have a right to voice grievances and that all grievances are acted upon in a timely manner. Grievance Form will be completed and directed to appropriate department or individual for response- not to exceed 21 days. 1.Resident #5 had diagnoses which included chronic obstructive pulmonary disease (lung disease), dementia and schizophrenia (brain disorder). The Minimum Data Set (a resident assessment tool) dated 01/09/2026 documented the resident was cognitively intact, understood, understands. The Minimum Data Set, dated [DATE] documented that it was very important to them to take care of their personal belongings or things. Review of a yellow spiral notebook titled Communication Book at the [NAME] Nurses Station on 03/09/2026 at 10:30 AM, revealed a documented entry dated 02/28/2026 that Resident #5's missing blanket was cream, not blue. Review of a Personal Property Loss/Damage Report provided by the Director of Social Work on 03/09/2026 at 11:45 AM, documented a report for Resident #5 was initiated on Sunday 02/22/2026 by the Director of Activities. The report documented Resident #5's family member reported the loss of a crochet lap blanket. The social worker outcome/resolution was not completed. There was no documentation that the facility was actively working toward resolution of this complaint/grievance. Review of Progress Notes dated 12/01/2025 to 03/11/2026, documented no evidence of missing personal property. During an interview on 03/05/2026 at 10:59 AM, Resident #5 stated they were missing a blanket made for them by their niece. They stated everyone is aware and a lost report was done. They stated the blanket has been missing for a few weeks and has not been returned and they minded. During interviews on 03/06/2026 at 3:15 PM and 03/09/2026 at 10:58 AM, Resident #5 stated they have not heard anything about their blanket, and it has been three (3) weeks. They stated they minded not having it because their niece made it for them and it could not be replaced. The resident described blanket as crochet, two (2) colors beige and a very light orchid color. 2.Resident #6 had diagnoses which included chronic obstructive pulmonary disease (lung disease), diabetes, and (continued on next page)</p>		

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>obesity. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact, understood, and understands. The Minimum Data Set, dated [DATE] documented that it was very important to them to take care of their personal belongings or things. Review of copied spiral notebook paper provided by Housekeeping/Laundry Director on 03/09/2026, revealed a handwritten note that was dated 9/5 and documented Resident #6 is missing two (2) pairs of pants. One is black and the other is blue. There was another handwritten note dated 02/26/2026 that Resident #6 said they were missing two (2) pairs of pants, blue and black like the pair they have in their closet. Review of Progress Notes dated 09/01/2025 to 03/11/2026 documented no evidence of missing personal property. During an interview on 03/05/2026 at 11:53 AM, Resident #6 stated they have two (2) pairs of pants that have been missing for over six (6) months. They described them as sweatpants but silky, one pair was black, and the other was navy blue. They stated they reported it to someone in September and had just mentioned it to laundry again last week. During an interview on 03/09/2026 at 8:46 AM, Resident #6 stated their pants have not been found or returned to them and it is upsetting. During interviews on 03/09/2026 at 8:41 AM and 11:20 AM, Laundry Aide #1 stated when it is brought to their attention by staff, or a resident that laundry is missing they look in the laundry department. They stated if they cannot find missing laundry they write it in the laundry communication book, so other laundry aides are aware. Laundry Aide #1 stated they were not aware of any lost reports or grievances being completed for missing items. They stated they were not aware of any missing pants for Resident #6. During an interview on 03/09/2026 at 9:03 AM, Registered Nurse #1, [NAME] Wing Unit Manager stated when a residents' personal property goes missing it should be documented in the resident's electronic medical record, family should be notified, and staff search for the items. They stated other departments are notified by email communication. Registered Nurse #1, [NAME] Wing Unit Manager stated they were not aware of any forms that need to be completed for missing personal property. They stated they were not aware of the process when missing personal property is not located and should be aware of the policies, processes so they can respond appropriately. They stated Resident #5 had been missing their blanket for some time, months, maybe two (2) months, and it has not been located. They were not aware of Resident #6's missing pants. During an interview on 03/09/2026 at 10:24 AM, Certified Nurse Aide #1 stated if a resident was missing something out of their room, they would check the resident's room. If they were unable to locate something they would document, it the unit communication book. They stated it was important to locate missing resident property because it was their belongings. During an interview on 03/09/2026 at 11:30 AM, Housekeeping/Laundry Director stated they do not have or maintain inventory records for residents' personal belongings. They stated when something is reported missing, they place it in the communication book with a description. They stated most times things are found. Housekeeping/Laundry Director stated if something is not found a lost report is filled out and given to interdisciplinary team members to complete, then the social worker ends up with the lost report. They stated they were aware that Resident #6 has been missing pants but were not aware if a lost report was completed. They stated a lost report was initiated for Resident #5's missing blanket last month. During an interview on 03/09/2026 at 11:37 AM, the Director of Social Work stated that when a resident's property is missing, a nurse will let them know and they initiate the form Personal Property Loss/Damage Report, based on the information received. They stated it is discussed, shared with each department during morning meeting. The Director of Social Work stated they did not know what the process was if missing personal property was not located. They stated that policies and procedures were available to them but that they were not familiar with the grievance process and would have to talk with the Administrator about it. The Director of Social Work stated they were aware of Resident #5's missing blanket, but not aware that Resident #6 was missing pants. During an interview on 03/10/2026 at 1:50 PM, the Director of Social Work stated they spoke with Resident #6 who informed them of their missing pants. They stated a personal property loss report was not completed to their knowledge at the time Resident #6's reported them missing. They stated laundry (continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>placed a note regarding Resident #6's missing pants into their communication book. They stated it was important to complete grievance forms to have a paper trail, record of missing property because it was the resident rights, this is their home. During an interview on 03/10/2026 at 1:56 PM, Licensed Practical Nurse #1 stated if they were notified of missing personal property, they would get the nursing supervisor involved and they would look for the reported missing item. They stated they were unaware of there being a form that needs to be completed for missing property. They stated residents have the right to have their personal property maintained, this is their home and personal belongings are important to them. They stated missing property needs to be located or replaced by the facility. During an interview on 03/11/2026 at 12:00 PM, the Director of Nursing stated there were no documented inventory records for Resident #5 and Resident #6 and there should be. They stated it was important for resident's personal belongings to be inventoried because they are significant to the resident and all they have. They stated completing grievances was important because it is the residents' voice, letting the residents know their concerns are known, being investigated and being addressed. The Director of Nursing stated they did not know why grievances were not initiated for Resident #5, Resident #6 and that they should have been. During an interview on 03/11/2026 at 12:24 PM, the Administrator stated they expected if any personal property was lost or missing, the policy would be followed. They stated the Grievance Officer, the Director of Social Work, should be notified and a grievance completed and followed appropriately. They stated it was important for every missing item to have a grievance attached. They stated it could be construed as misappropriation and the goal is to investigate to rule out misappropriation. 10 NYCRR 415.3(d)(1)(ii)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>Based on observation, interview, and record review conducted during a survey, the facility did not ensure residents were assessed for risk of entrapment from bed rails prior to installation, risks and benefits of bed rails were reviewed with the resident or resident representative, and informed consent was obtained prior to the installation of bed rails for one (1) (Resident #87) of three (3) residents reviewed. Specifically, Resident #87's bed rail was loose and not secure to the bedframe and the resident was not assessed for risk of entrapment from the bed rails. Additionally, the risks and benefits of bed rail use were not reviewed with the resident or their representative and consent was not obtained prior to bed rail use. The finding is: The policy and procedure titled Bed Assist Devices revised 11/2024 documented bed assist devices are mobility devices used to aid in resident independence with bed mobility and/or to improve resident participation in bed mobility during care. Occupational Therapy and Physical Therapy will assess resident's bed mobility skills and their ability to appropriately utilize the bed assist device. Therapy will obtain consent for bed assist device from appropriate responsible party or resident and review the risks and benefits from the use of bed rails. Therapy will document the results of training and notify nursing staff. Residents' ability to continue to use the bed assist device will be monitored quarterly. Resident #87 had diagnoses that included osteomyelitis (infection of the bone) of vertebra (bones forming spinal column), right hemiparesis (weakness of one side of body), and urinary tract infection. The Minimum Data Set (a resident assessment tool) initiated on 03/08/2026, that was in progress, documented Resident #87 had moderate cognitive impairment. The Order Summary Report for 03/01/2026-03/31/2026 documented an order dated 03/06/2026 to encourage the resident to change position when in bed turn to side, off of their bottom. There was no order for side rail use documented. The Kardex Report (a guide used by staff to provide care) dated 03/11/2026 documented Resident #87's bed mobility was substantial/maximal assist of one (1) staff with bilateral bed assist bars for rolling. For lying to sitting on the side of the bed the resident needed substantial/maximal assist of one (1) staff with bilateral bed assist bars for rolling and assistance of two (2) staff for supine (lying on back) to/from edge of bed. The comprehensive care plan initiated 03/04/2026 documented Resident #87 had limited physical mobility related to a sacral ulcer (skin wound) and history of a stroke. Interventions initiated on 03/04/2026 documented substantial/maximal assist of one (1) staff with bilateral bed assist bars for rolling in bed, and assistance of two (2) staff for supine to the edge of bed. The Physical Therapy Evaluation and Plan of Treatment dated 03/04/2026 documented Resident #87 was laying supine in bed and rolled with a moderate assist of one (1) and used bed assist bars to offload and pressure relief. Equipment during tasks included using bedrails bilaterally. There was no documentation that the risks or benefits of the use of side rails were discussed that informed consent was obtained prior to their use, and that an entrapment risk was completed. Review of Progress Notes dated 03/03/2026 through 03/09/2026 revealed no documented evidence that Resident #87 was provided with education on the risks and benefits of the bed assist devices or that informed consent was obtained prior to their use. Physical Therapy Evaluation and Plan of Treatment and Treatment Encounter Notes dated 03/04/2026 through 03/10/2026 did not document evidence that Resident #87 was provided education on risks and benefits of the bed assist devices or that informed consent was obtained prior to use. There was no documentation that an entrapment risk was completed. During observations on 03/05/2026 at 11:39 AM, 03/09/2026 at 8:53 AM, and 03/10/2026 at 10:23 AM, Resident #87's bed had bilateral bed assist devices at the head of the bed. The bed assist device on the right side of the bed was loose, easily moved back and forth away from the mattress. When the bed assist device was pulled/pushed away from the side of the mattress there was a gap of three (3) inches between the mattress and the bed assist device. The bed assist device on the left side of bed was loose and did (continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>not move away from the mattress. During an interview and observation on 03/10/2026 at 10:37 AM, Certified Nurse Aide #3 stated that the therapy department issues bed assist devices for the resident's beds. They stated there was nothing they ever had to do with the bed assist devices. They stated they make sure they are in place, locked and in the up position on the bed. Certified Nurse Aide #3 observed the right-side bed assist device on Resident #87's bed, stated it was loose, and it would not be safe to hold on to as it could fall off the bed. They stated they were not aware the bed assist device was loose, and that they usually get another staff member to assist with Resident #87's bed mobility. During an interview and observation on 03/10/2026 at 10:46 AM, Licensed Practical Nurse #1 stated they were responsible for making sure bed assist devices were in place and secure to the resident's bed. They stated they were not aware of any side rail assessments that were completed by nursing and were not responsible for assessing for siderail entrapment. Licensed Practical Nurse #1 stated physical therapy determined if a resident should have bed assist devices. They stated they were not aware of any concerns with Resident #87's bed assist devices until Certified Nurse Aide #3 reported it to them. Upon observing Resident #87's bed assist devices they stated the left side bed assist device was not completely tightened, and that the right-side bed assist device had more give, moved away from the mattress creating a space between the mattress and the bed assist device. Licensed Practical Nurse #1 stated it was important for the bed assist devices to be secure for safety, as residents utilize them for turning/positioning. During an interview on 03/10/2026 at 10:57 AM, Registered Nurse #1, [NAME] Wing Unit Manager stated they were not responsible for completing any assessments related to bed assist devices. They stated if they were notified of a bed assist device not working properly, they would notify the maintenance department through an electronic work order. Registered Nurse #1, [NAME] Wing Unit Manager stated the bed assist devices are only used to assist with bed mobility, they are not used as a fall prevention or restraint. Registered Nurse #1, [NAME] Wing Unit Manager stated a loose bed assist device was a safety concern and could be considered an entrapment risk if not secured properly. During an interview and observation on 03/10/2026 at 11:09 AM, the Director of Maintenance stated bed assist devices are put on beds by the maintenance department and taken off beds as needed. They stated they are usually notified by therapy via a work order when bed assist devices need to be applied to a resident's bed. They stated whenever a resident is discharged, the bed assist devices are removed by housekeeping or maintenance. The Director of Maintenance stated they check the bed assist devices on residents' beds twice a year with the therapy department. They stated checks of the bed assist devices involve utilizing a measurement kit to check for gaps between the mattress and the rail. Upon observing Resident #87's right side bed assist device they stated it was a little bit loose, there was a gap between the mattress and rail and there should not be. During an interview on 03/10/2026 at 11:24 AM, the Director of Rehab Services stated therapy completes an assessment for the use of bed assist devices as part of their initial evaluation of a resident upon admission. They stated physical therapy assesses bed mobility and determines if the use of bed assist devices will improve and/or maintain bed mobility and assist with transfers. They stated there is no formal consent received by residents or resident representative for the use of the bed assist devices and no form was completed for entrapment. They stated risks and benefits for bed assist device use are reviewed with residents at the time of placement by therapy. During an interview on 03/10/2026 at 1:35 PM, Resident #87 stated they never received any education on concerns related to the use of the bed assist devices on their bed and the bed assist devices helped them with their mobility in bed. During an interview on 03/10/2026 at 3:05 PM, the Director of Nursing stated if bed assist devices were deemed appropriate, therapy would speak to family and residents, and the rails would be put on by maintenance. The Director of Nursing stated it was therapy's responsibility to speak to the family and residents to explain risks and benefits and obtain consents. They stated therapy was responsible for placing a progress note in the medical record of who they spoke to and that they explained risks and benefits. The Director of Nursing stated they would expect a note to be documented in the residents' chart, to (continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>ensure this was done. They stated therapy was also responsible for assessing for entrapment and completing follow up assessments of bed assist devices to assess for risk of injury or harm. The Director of Nursing stated if nursing had a concern with the bed assist device, they would expect them to notify maintenance through an electronic work order. During an interview on 03/10/2026 at 3:16 PM, the Director of Rehabilitative Services stated entrapment tests were initially performed by the maintenance department upon installation and subsequently tested quarterly by therapy staff. Therapy staff conducted entrapment tests using the device manufacturer's Bed System Measurement Device Test Results Worksheet. The entrapment test criteria for a passed or failed result were based on the manufacturer's recommendations. The Bed System Measurement Device Test Results Worksheet was not saved in the resident's file and was discarded after the test was conducted. During an interview on 03/11/2026 at 10:25 AM, the Director of Maintenance stated Resident #87's bed was moved from another room, and the assist bars were already installed from the previous resident who used the bed. The Director of Maintenance stated there was no work order in the facility's system for installation and assessment of the assist bars because the bed rails were already installed on the bed. During an interview on 03/11/2026 at 2:02 PM, the Administrator stated they would expect staff to follow the facility's policy and follow the manufacturer's specifications. 10 NYCRR 415.12(h)(1)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during the survey, the facility did not store food in accordance with professional standards for food service safety. Specifically, one (1) (West Wing Unit) of two (2) unit nourishment refrigerators contained unlabeled, out of date food and drink items, and personal food was stored with residents' food. The finding is: The policy titled Dietary Sanitation revised 02/26, documented its purpose was to prevent the incidence of food borne illness through safe food handling procedures. Stored foods to be held or leftovers should not exceed a 72-hour period in refrigeration. Leftovers should be covered, labeled and dated, put in the freezer right away or if put in refrigerator, use within 72 hours (3 days) or discard. Juices, iced tea should be used within seven (7) days. All food items must be dated once they are opened. The policy and procedure titled Dietary Services revised 01/26, documented the facility stores, prepares, distributes and serves food under sanitary conditions, and in accordance with the sanitary requirements. Observation of the [NAME] Wing Unit nourishment refrigerator on 03/06/2026 at 11:03 AM revealed the following items:-opened, used 32 fluid ounce container of thickened dairy drink dated 12/5 in black marker with best if used by date 02/12/2026. -opened, used 32 fluid ounce container of thickened dairy drink dated 1/16 in black marker. -opened, used 64 fluid ounce opened container of apple juice dated 2/20 in black marker. -one (1), 5.3-ounce unopened, unlabeled personal vanilla yogurt best by date [DATE]. During an interview on 03/06/2026 at 11:12 AM, Certified Nurse Aide #3 stated the items in the nourishment refrigerator come from the kitchen. They stated whoever opens a beverage container would be responsible for dating it. They stated it was important for food to be labeled because stuff goes bad. Certified Nurse Aide #3 stated personal food items should be labeled with a name, so they know who it belongs to. They stated you would not want to give someone's personal food to somebody else. They stated food and beverages in the refrigerator should be dated and labeled because they are only good for so long. During an interview and observation on 03/06/2026 at 11:19 AM, the Registered Dietician stated they were responsible for checking the nourishment refrigerators, since yesterday. They stated food and beverages should be labeled and dated and are only good for three days. They stated after three days of being opened, food and beverages should be thrown away to prevent food born illness. Upon observation of outdated beverages, they removed them from the refrigerator stating they were bad and beyond three days old. They removed the personal yogurt stating they were unable to say where it came from and that it was expired. During an interview on 03/11/2026 at 11:07 AM, Food Service Worker #1 stated all kitchen staff were responsible for labeling, dating food and beverages when opened. They stated once opened they are only good for three days. After the third day they should be disposed of to prevent food borne illness. During an interview on 03/11/2026 at 12:24 PM, the Administrator stated they expected facility policy to be followed regarding labeling and dating of food and beverages. They stated after 72 hours; it should be discarded. 10 NYCRR 415.14(h)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>Based on observation, interview, and record review conducted during a survey, the facility did not ensure regular inspections of all bed frames, mattresses, and rails were conducted as part of a regular maintenance program to identify areas of possible entrapment (when a person is trapped in a hospital bed's rails, mattress or frame, preventing them from moving) for two (2) (Residents #1 and #71) of three (3) residents reviewed for side rail use. Specifically, Residents #1 and #71's bed rails were checked for possible zones of entrapment using a bed system measurement device that lacked a measurement component per the manufacturer's specifications. Additionally, the facility did not ensure Residents #1 and #71's bed rails, which were used and purchased separately from the bed frames, were compatible. The findings are: The policy titled Bed Assist Devices, revised 11/2024, documented the Maintenance Department, OT (Occupational Therapy) Department or Housekeeping will be involved in the placement and removal of the bed assist devices. Along with performing an Entrapment Gap Tool Test when applied to the bed, and on a monthly audit for entrapment. The policy titled Bed Entrapment Prevention and Assessment, signed by the Administrator 01/2026, documented the facility shall conduct regular assessments of bed systems (frames, mattresses, and rails) to ensure they meet the dimensional safety to prevent resident injury. Every resident bed in the facility will undergo a formal entrapment measurement audit annually. The facility will utilize specialized measurement tool. All inspection results, including specific measurements, must be documented in the Preventative Maintenance logs. 1. Resident #1 had diagnoses that included dementia, osteoporosis (disease that causes bones to become weak) and muscle weakness. The Minimum Data Set (a resident assessment tool), dated 02/13/2026, documented the resident was understood, understands, and had moderately impaired cognition. Resident #1 was independent with rolling left and right in bed and required substantial maximal assistance for lying to sitting on side of bed. No bed rail use was indicated in the assessment. The comprehensive care plan, revised 03/07/2026, documented Resident #1 had limited physical mobility related to weakness. Interventions initiated on 02/14/2023, included resident required partial moderate assistance of one (1) staff member with bilateral bed assist bars for supine (lying flat on back) to sit at edge of bed; and was modified independent for rolling in bed with bed assist bars. Intermittent observations made on 03/05/2026 at 9:57 AM, 03/09/2026 at 10:23 AM, and 03/10/2026 at 10:25 AM revealed Resident #1's bed was positioned with one side up against the wall in their bedroom, and the bed had bilateral assist rails. During an observation on 03/10/2026 at 11:52 AM, a manufacturer's label revealed Resident #1's bed had bilateral bed assist rails that did not have a manufacturer's label and were affixed with screws to the underside of the bed springs and the surface of the bed springs with a wooden board above the pivot point of the head of the bed. 2. Resident #71 was admitted to the facility with multiple sclerosis and sepsis. Review of the Minimum Data Set (a resident assessment tool) dated 1/22/2026 documented that Resident #71 was cognitively intact, understood by others, and understands others. Further review of the Minimum Data Set documented that Resident #71 required substantial assistance from staff to move right to left while in bed. The comprehensive care plan revised 01/21/2026, documented Resident #71 had limited physical mobility related to altered mental status and weakness. Interventions initiated on 02/07/2023 included the resident required substantial maximal assistance of one (1) staff member with bilateral bed assist bars for rolling. During an observation on 03/11/2026 at 8:15 AM, Resident #71's bed was positioned with one side up against the wall in their bedroom, and the bed had bilateral assist rails. The bed rails were noted to be slightly loose at the base but did not come out of the base. The bed assist rails, and bed frame did not have a manufacturer's label and the bilat assist rails were affixed with screws to the underside of the bed springs and the surface of the bed springs with a wooden board above the pivot point of the head of the bed. During an interview on 3/11/2026 at 8:36 AM with Resident #71, they stated that the bed assist bars were on the bed when they were admitted (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Lockport Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 Lincoln Ave Lockport, NY 14094	
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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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>into the facility. They stated that they have seen maintenance check the bed assist rails but could not remember if they measured the bed rails. Review of the undated Owner's Assembly, Operation and Maintenance Manual for the beds used by Residents #1 and #71, provided by the Director of Maintenance on 03/10/2026, documented replacement mattresses and bed side rails with dimensions different than the original equipment supplied or specified by the bed manufacturer may not be interchangeable. Variations in bed side rail design and thickness or density of the mattress could cause entrapment. Only authorized replacement parts were to be used. Review of the Bed System Measurement Device Instruction Manual, retrieved from the manufacturer's website on 03/10/2026, documented the measurement device included one (1) cone, one (1) cylinder, and one (1) digital scale. Test methods included four (4) test zones, and the tests may be performed in any order, as long as all tests on all rails were completed. Additionally, the instruction manual documented the digital scale was used to apply 12-pounds of force to the cone in tests 1 and 2, and annual calibrations of the measurement device were recommended. During an observation and interview on 03/10/2026 at 1:47 PM, the Director of Maintenance stated the facility used a bed system measurement device to assess risk for entrapment on bed assist rails. The Director of Maintenance stated the maintenance department performed an entrapment test upon bed assist rail installation, and the therapy department performed bed assist rail entrapment tests quarterly thereafter using the measurement device. They stated the maintenance department installed bed assist rails in pairs and residents either received two (2) bars or no bars because the mattress would drift if only one (1) bar was installed. The Director of Maintenance stated there was no manual available for the measurement device and it was missing the scale. The Director of Maintenance stated because the facility used the same rails for all beds, the scale was not necessary and was probably lost inside someone's desk. During an interview on 03/10/2026 at 3:16 PM, the Director of Rehab Services stated entrapment tests were initially performed by the maintenance department upon installation and subsequently tested quarterly by therapy staff. They stated therapy staff conducted entrapment tests using the device manufacturer's bed system measurement device test results worksheet and the entrapment test criteria for a passed or failed result was based on the manufacturer's recommendations. The Director of Rehab Services stated the bed system measurement device test results worksheet was not saved in the resident's file and was discarded after the test was conducted. They stated the entrapment measurement device did not need to be calibrated, they were not familiar with the scale component, and they had used the device without the scale since they had been working at the facility over the last six years. During an interview on 03/11/2026 at 9:40 AM, Physical Therapy Assistant #1 stated all bed assist rail assessments and entrapment tests should be tested quarterly. They stated therapy staff were trained to use the entrapment measurement device by a demonstration from the Director of Rehab Services; not all zones were applicable when testing for entrapment, and they were not familiar with the scale component for the entrapment measurement device. During an interview and review of bed assist rail schematics on 03/11/2026 at 10:25 AM, Maintenance Technician #1 stated they never read the warning from the Owner's Assembly and Maintenance Manual for the beds used by Resident's #1 and #71 regarding the use of manufacturer's parts. The beds were implemented by the facility in the year 2000, and the bedrails had been installed on the beds over the past 15 years. During an interview on 03/11/2026 at 2:02 PM, the Administrator stated they would expect staff to follow the facility's policy and follow the bed manufacturer's specifications. They were not aware of the specificity of using the manufacturer's bed rails for the beds. If the manufacturer stated specific equipment was needed, they would follow the manufacturer's specifications for safety reasons. 10NYCRR 415.29(b)</p>		

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NAME OF PROVIDER OR SUPPLIER Lockport Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 Lincoln Ave Lockport, NY 14094	
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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation, interview and record review conducted during a Standard survey completed on 3/11/2026, the facility did not ensure that posted nurse staffing information contained the required information on a daily basis. Specifically, the actual hours that licensed nurses and Certified Nurse Aides worked and the resident census were not included in the posted staffing information. The finding is: The policy titled Daily Posting of Staffing Information and Resident Census dated 01/2026 documented that the facility will post daily staffing information and resident census. It documented that the 11:00 PM-7:00 AM shift will initiate the daily staffing report, include the schedule of all Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides who are scheduled to work the day of the report, the total hours of each category will be included, at the beginning of each shift the Nursing Supervisor or designee will update report and add current resident census. An observation of the Daily Staffing Report at the reception desk on 03/10/2026 at 10:00 AM, revealed the report for 03/06/2026 documented the names of the nursing staff working for the 7:00 AM to 3:00 PM, the 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM shifts. There was no documentation of the resident census and the nursing staff actual hours. Review of the Daily Staffing Report from 02/06/2026 to 3/10/2026 revealed there were no documented hours for nursing staff and no documented resident census. During an interview on 03/10/2026 at 1:30 PM with the Nursing Secretary, they stated that they stopped putting the number of nursing hours and the resident census since they started sending that information to their corporate headquarters sometime in February 2026. They stated that they did not realize that information was supposed to be posted daily. During an interview on 03/10/2026 at 1:35 PM with the Director of Nursing, they stated that the nurse staffing information and the resident census should be posted on the daily staffing sheet. Interview on 03/11/2026 at 12:34 PM with the Administrator, they stated they expect the staff to post the nursing staff hours and the resident census on a daily basis. 10NYCCR 415.13</p>		