| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335638 | A. Building<br>B. Wing | 04/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Buffalo Center for Rehabilitation and Nursing | 1014 Delaware Ave<br>Buffalo, NY 14209 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the Abbreviated Survey (Complaint #NY00364627), the facility did not ensure that each resident was treated with respect and dignity in an environment that promotes maintenance or enhancement of his or her quality of life; recognizing each resident's individuality and protect and promote the rights of the residents for three (3) (Resident #1, 2, & 3) of three (3) reviewed. Specifically, an altercation amongst staff occurred in front of residents, was recorded and posted on social media.<br><br>The finding is:<br><br>The policy and procedure titled Quality of Life/Dignity dated 5/2024 documented each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall be always treated with respect and dignity. Residents private space shall be respected at all times.<br><br>The policy and procedure titled Resident Rights dated 5/2024 documented all residents shall be treated with kindness, respect, and dignity.<br><br>The policy and procedure titled Cell Phone Use dated 10/2019 documented to maintain privacy and confidentiality rights of our residents; to be in compliance with Health Insurance Portability and Accountability Act (HIPAA), cellular telephones or any other electronic device is prohibited in resident areas. HIPAA Protected Health Information (PHI) should never be stored, shared or accessed on a personal device. Inappropriate use of cellular device by an employee includes, but is not limited to, photographing or videoing residents, sharing HIPPA protected information via unsecured networks such as text messaging, or electronically sharing resident information that does not meet the minimum necessary standard on a personal device.<br><br>Resident #1 had diagnoses including anxiety, multiple sclerosis, and diabetes. The Minimum Data Set (a resident assessment tool) dated 11/15/24 documented that Resident #1 had severe cognitive impairment, was sometimes understood and sometimes understands.<br><br>Resident #2 had diagnoses including Alzheimer's disease, hypertension (high blood pressure), and diabetes. The Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment, was sometimes understood and usually understands.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #3 had diagnoses including anxiety, depression, and diabetes. The Minimum Data Set, dated [DATE] documented that Resident #3 had moderate cognitive impairment, was understood and understands.<br><br>Review of Complaints/Incidents Tracking System ACTS/ Investigative Report received on 12/13/24 at 12:36 PM documented a video was shared on social media that involved a fight amongst facility staff.<br><br>During an observation on 4/10/25 at 10:21 AM of the video posted on social media from 12/10/24 at 7:07 PM revealed an altercation amongst staff members. Yelling and screaming was heard on the video. Licensed Practical Nurse #1 and Certified Nurse Aide #1 were seen throwing objects in a resident care area with residents present in the lounge area in front of the nurse's station.<br><br>The facility investigation revealed a written/signed statement dated 12/12/24 by Licensed Practical Nurse #2's that they came up to the third floor and observed Licensed Practical Nurse #1 throw a nutritional supplement and a stapler at Certified Nurse Aide #1. Certified Nurse Aide #1 threw French fries and cranberry juice back at Licensed Practical Nurse #1. Licensed Practical Nurse #2 attempted to remove Licensed Practical Nurse #1 from the situation. Licensed Practical Nurse #1 was yelling at Certified Nurse Aide #1 and pushed Licensed Practical Nurse #2 in an attempt to get near Certified Nurse Aide #1. Licensed Practical Nurse #2 then called 911, checked on the residents in the lounge area, and ensured they were safe. The date and time of the fight was not documented on the statement.<br><br>Review of a documented interview on 12/11/24 between Licensed Practical Nurse Unit Manager #3 and Resident #1 revealed that on 12/10/24 Resident #1 was in the lounge while the fight between staff occurred. Resident #1 stated to Licensed Practical Nurse Unit Manager #3 that Licensed Practical Nurse #1 and Certified Nurse Aide #1 were yelling at one another. Resident #1 stated they felt safe.<br><br>During a telephone interview on 4/10/25 at 11:28 AM, Registered Nurse #1 stated the fight between Licensed Practical Nurse #1 and Certified Nurse Aide #1 occurred on 12/10/25 in the evening on the 3rd floor at the nurse's station. A video was posted on social media, and it was a HIPPA (privacy rights) violation as there were residents located and seen in the area and was against resident rights. They were unaware of who recorded the video.<br><br>On 4/10/25 at 3:20 PM a telephone interview was attempted with Licensed Practical Nurse #1 without success.<br><br>During a telephone interview on 4/10/25 at 3:42 PM, Certified Nurse Aide #1 stated they were involved in a fight on 12/10/25 at 7:00 PM with Licensed Practical Nurse #1. The incident occurred in front of residents, and it was inappropriate and disrespectful. We should not have been fighting in the resident's home. Resident's #1, 2, & 3, I'm sure were shocked and frightened. Certified Nurse Aide #2 had recorded the fight on their cell phone and they saw the incident posted on social media.<br><br>During an interview on 4/10/25 at 4:10 PM, Certified Nurse Aide #3 stated there were so many staff members and the scene was chaotic. They stated they were sure the residents in the area were confused, scared and could have been injured. The whole thing was undignified, and should not have happened.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/11/25 at 8:30 AM, Licensed Practical Nurse #2 stated the fight between Licensed Practical Nurse #1 and Certified Nurse Aide #1 took place in front of Resident's #1, 2 & 3 after supper at 7:00 PM. The yelling and screaming made them feel scared, intimidated, and was undignified. We would not want to see that in our home, and the resident's should not have had to see that in their home. Resident's 1, 2, & 3 were posted in the social media post which was a breach in HIPPA (privacy rights) and a dignity concern.<br><br>During an interview on 4/11/25 at 8:45 AM, Registered Nurse #2 stated cell phone use was prohibited and the social media video violated residents' privacy.<br><br>During an interview on 4/11/25 at 9:00 AM, Certified Nurse Aide #2 denied video recording the fight and stated photographing and video recording of resident's was against HIPPA (privacy rights) and was disrespectful. This was their home.<br><br>During an interview on 4/11/25 at 11:27 AM, Resident #1 had no recollection of the staff altercation on 12/10/24 and answered yes when asked if the staff treated them with respect and dignity.<br><br>During an interview on 4/11/25 at 11:45 AM, Resident #2 stated they were treated well here in the facility. Resident #2 could not recall the staff altercation from 12/10/24.<br><br>During an interview on 4/11/25 at 12:02 PM Resident #3 stated fighting would be horrible. There's a time and place for fighting. Resident #3 was unable to recall the staff altercation on 12/10/24.<br><br>During an interview on 4/11/25 at 1:15 PM, the Director of Nursing stated the staff acted inappropriately in the resident's home. The fighting, yelling, and commotion was unprofessional and disrespectful to all residents. Licensed Practical Nurse #1 and Certified Nurse Aide #1 actions created an undignified environment. The social media post violated Resident #'1, 2 & 3's privacy rights.<br><br>During a telephone interview on 4/11/25 at 1:37 PM, the Administrator stated the fight, video recording, and staffs' behavior must have made the residents feel uncomfortable. The social media post violated resident rights, was against facility policy, and was unacceptable.<br><br>10NYCRR 415.3 (c) (1) (i) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on interview and record review conducted during a Complaint (#NY00375418) investigation, it was determined the facility did not ensure that all violations of abuse are thoroughly investigated for one (1) (Resident #4) of three (3) residents reviewed. Specifically, Resident #4 had an injury of unknown origin that was not thoroughly investigated.<br><br>The finding is:<br><br>A policy and procedure titled Abuse dated 12/2022 documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. The policy and procedure documented the facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property.<br><br>A policy and procedure titled Accidents - Incidents dated 7/2020 documented the facility would monitor and evaluate all occurrences of accidents or incidents or adverse events occurring on the facility's premises which is not consistent with the routine operation of the facility or care of a particular resident. These occurrences must be evaluated and investigated.<br><br>A policy and procedure titled Investigations - Injury of Unknown Etiology dated 11/2019 documented an investigation of all injuries of unknown etiology including bruises, abrasions and injuries of unknown origin source, will be conducted by an individual appointed by the Administrator, to ensure that the safety of our residents has not been jeopardized, and to investigate any potential abuse or neglect.<br><br>Resident #4 was admitted to the facility with Alzheimer's disease and dysphagia (difficulty in swallowing). The Minimum Data Set (a resident assessment tool) dated 3/25/2025 documented Resident #4 was severely, cognitively impaired, was sometimes understood by others and sometimes understood others. The resident had no upper body impairments and was dependent on others for mobility.<br><br>The undated comprehensive care plan documented that Resident #4 had impaired cognition, required assistance with activities of daily living, had limited physical mobility related to pain and weakness. Interventions included to ask yes or no questions to determine the resident's needs.<br><br>A progress noted dated 3/12/2025 at 7:15 PM completed by License Practical Nurse Unit Manager #7 documented that during rounds, Resident #4 was found leaning to their left side. When the staff repositioned the resident, they discovered bruising on Resident #4's left arm and shoulder. The Medical Director was notified with new orders to discontinue Eliquis (a blood thinning medication) and therapy to improve core strength.<br><br>A progress note dated 3/13/2025 at 2:57 PM documented the Occupational Therapist performed range of motion (ROM, moving arms or legs to determine how far they can move) exercises on Resident #4. The noted documented that Resident #4 did not have pain during the exercises.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An SBAR (situation, background, assessment, recommendation) Communication Form and Progress Note completed by Licensed Practical Nurse Supervisor #6 dated 3/15/25 at 7:10 AM documented that Resident #4 had decreased mobility and this sign/symptom, and condition had not occurred before.<br><br>A late entry progress note dated 3/15/2025 at 9:53 AM documented that Licensed Practical Nurse Supervisor #4 went to see a bruised area on Resident #4 at 6:00 AM, assessed Resident #4 and noted a protrusion within a bruised area on Resident #4's left shoulder. The progress noted documented that Resident #4 flinched from pain. Resident #4 was medicated with acetaminophen (pain reliever) with no relief and then was transported to the hospital.<br><br>A progress noted dated 3/15/2025 at 8:59 AM completed by Licensed Practical Nurse Supervisor #5 documented that Resident #4 was admitted to the hospital with a fractured clavicle (bone connecting shoulder blade to breastbone).<br><br>During an interview on 4/10/2025 at 8:55 AM, Licensed Practical Nurse Supervisor #6 stated there wasn't an incident report or investigation completed because Resident #4 had a bruise there. They stated they probably should have started an investigation and called the Director of Nursing because a protrusion was noted and that was new. They also stated that a Registered Nurse did not assess the resident because there were no Registered Nurses on duty at that time. They stated that they texted pictures of the shoulder to Licensed Practical Nurse Unit Manager #7.<br><br>During an interview on 4/10/2025 at 10:58 AM, Licensed Practical Nurse Unit Manager #7 stated that the resident had horrible posture and that that's what they assumed caused Resident #4's initial bruise from a few days ago. They stated that this incident with the bone protruding from the bruise should have been reported to the Director of Nursing and the Administrator. They stated that if there was an injury of unknown origin, an investigation would have been initiated; employees would provide statements, and they would go back 72 hours to obtain employee statements to determine how the injury happened. They stated they received a text from one of the nursing supervisors and they advised them to send Resident #4 to the emergency room.<br><br>During an interview on 4/10/2025 at 12:29 PM, Licensed Practical Nurse Supervisor #5 stated that an investigation was not started because there was an investigation concerning the resident's bruise from a few days ago. They stated that they were not sure if a Registered Nurse was in the building at the time to do an assessment.<br><br>During an interview on 4/10/2025 at 1:00 PM, the Medical Director stated they would expect an investigation completed for an injury of unknown origin.<br><br>During an interview on 4/10/2025 at 1:38 PM, Certified Nurse Aide #4 stated they did not remember if they were asked for a witness statement or not. They stated that they get in-serviced on abuse during orientation and it was part of their annual education. They stated that if there was a bruise on a resident, they would report it to their nurse.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/10/2025 at 3:06 PM, the Director of Nursing stated that they did not get an x-ray for Resident #4's shoulder because the resident was not exhibiting any pain during the occupational therapy evaluation. They stated that a Registered Nurse assessment was not needed as they sent the resident to the hospital right away. They stated that the bump or protrusion on Resident #4's shoulder was part of the bruise that was previously investigated so they didn't initiate another investigation. They stated that they were on call and would have come into the facility if a resident needed a Registered Nurse assessment.<br><br>During an interview on 4/11/2025 at 8:31 AM, the Occupational Therapist stated they saw Resident #4 for a therapy evaluation related to the resident's positioning and core strength. They performed range of motion exercises on Resident #4's left arm and shoulder on 3/13/2025. They stated that Resident #4 at that time did not complain of pain and showed non-verbal signs of pain (grimacing, wincing, or guarding motions). They stated that if they saw a bone protruding where the bruise was located, they would have told nursing right away.<br><br>During an interview on 4/11/2025 at 9:18 AM, License Practical Nurse Supervisor #4 stated that they worked the overnight shift the morning it happened to Resident #4. They stated that when they saw Resident #4 there was a bump protruding between the front and back of the resident's shoulder area where they were bruised. They stated that the bump was closer to the resident's neck. They stated that an investigation was not initiated because of the bruise that was found there a few days ago. They stated there was not a Registered Nurse in the building to do an assessment, so they did the assessment.<br><br>During an interview on 4/11/2025 at 1:31 PM, the Administrator stated that they did not do an investigation because Resident #4's bruise on their left shoulder was investigated before. They stated that they considered the bump or protrusion part of this bruise and so it did not need to be investigated.<br><br>10 NYCRR 415.4(b)(3) |