

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	

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 0600  Level of Harm - Actual harm  Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	
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 0600  Level of Harm - Actual harm  Residents Affected - Some	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review conducted during an Abbreviated Partial Extended survey (Complaint #NY00383127), the facility failed to protect residents from sexual and mental abuse by staff for four (4) (Residents #1, #2, #3, and #4) of six (6) residents reviewed for abuse. Specifically, Certified Nurse Aide #1 took personal photographs of heavily soiled incontinent residents in various stages of undress without their consent, including some with their buttocks and genitalia exposed. The photographs were posted on social media along with text messages and descriptions of the lack of resident care. Using the reasonable person concept, as referenced on the Centers for Medicare and Medicaid Services Psychosocial Outcome Severity guide, it was determined psychosocial harm occurred that is Substandard Quality of Care for Residents #1, #2, #3, and #4 that is not immediate jeopardy. The finding is: The policy and procedure titled Abuse, dated 06/2024, documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients by anyone. The facility prohibits any exploitation of the mentally and physically disabled residents in the facility. Mental/emotional abuse is the use of verbal and/or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Mental abuse includes abuse that is facilitated or enabled using technology (smart phones, other personal electronic devices and cameras) that demeans or humiliates the resident, regardless of whether the resident provided consent or the resident's cognitive status. The policy and procedure titled Photography - Still and Video, dated 02/2020, documented in order to ensure resident privacy, to provide optimal resident care, and to foster mutual respect between and among the residents, family and staff, the facility will ban audio or visual recordings of resident encounters, activity of daily living (ADL) assistance, care or procedures by residents, visitors and staff, unless specifically allowed by the applicable procedures or required by state law. 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), use of cellular telephones or any other electronic device is prohibited in resident areas. Protected Health Information should never be stored, shared or accessed on a personal device. Inappropriate use of a cellular device by an employee includes, but is not limited to, photographing or videorecording residents and sharing HIPAA (Health Insurance Portability and Accountability Act) protected information via unsecured networks. Resident #1 had diagnoses including generalized anxiety disorder, major depressive disorder, and selective mutism (a mental health condition where an individual was unable to speak in certain situations due to fear or anxiety). The Minimum Data Set (a resident assessment tool) dated 05/28/2025 documented Resident #1 was usually understood, usually understands, and had moderate cognitive impairment. They were frequently incontinent of both bowel and bladder. Resident #2 had diagnoses including morbid obesity, chronic kidney disease and hypothyroidism (thyroid disease). The Minimum Data Set, dated [DATE] documented Resident #2 was always understood, always understands and was cognitively intact. They were frequently incontinent of bowel and bladder. Resident #3 had diagnoses including encephalopathy (a disease of the brain), polyneuropathy (a disease process involving nerves), and anemia (a condition where the blood doesn't have enough healthy red blood cells or hemoglobin to carry adequate oxygen to the body's tissues). The Minimum Data Set, dated [DATE] documented Resident #3 was always understood, always understands and had severe cognitive impairment. They were frequently incontinent of bowel and bladder. Resident #4 had diagnoses including cerebral infarction (stroke), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body). The Minimum Data Set, dated [DATE] documented Resident #4 was usually understood, usually understands and had severe cognitive impairment. They were frequently incontinent of bowel and bladder. Review of the Complaints/Incidents Tracking System ACTS/Investigative Report received on 06/10/2025 at 10:52 AM revealed photographs were posted on social media by Certified Nurse Aide #1, as well as a text message that was sent to the Administrator. The photographs attached to the report revealed heavily soiled, incontinent residents in various stages of undress, with their buttocks and genitalia exposed. The social media post indicated it was publicly shared 825 times. Review of the social media pictures/posts revealed residents lying in bed in various stages of undress, some with their genitals and buttocks exposed; some with their torso, chest and legs exposed. Medical devices, equipment and skin conditions could also be visualized in some of the photos. The residents could be seen lying on heavily soiled linens and briefs. Some of the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint #NY00383127) the facility did not ensure that all alleged violations involving abuse and mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, to other officials (including to the State Survey Agency) for four (4) (Resident #1, #2, #3, and #4) of four (4) residents reviewed. Specifically, allegations of resident abuse were not reported within 2 hours to the New York State Department of Health and law enforcement agencies.</p> <p>The finding is:</p> <p>The policy and procedure titled Abuse dated 6/2024 documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients by anyone including but not limited to staff, family, friends, and residents of the facility. The Administrator and Director of Nursing are responsible for investigation and reporting. Report to the local law enforcement and appropriate State Agency(s) immediately (no later than two (2) hours after allegation/identification of allegation) by the Agency's designated process after identification of alleged/suspected incident. The local law enforcement authorities are to be notified of any instance of resident: abuse, exploitation, mistreatment, neglect, involuntary seclusion or misappropriation of personal property which is a criminal act.</p> <p>Resident #1 had diagnoses including generalized anxiety disorder, major depressive disorder, and selective mutism (a mental health condition where an individual was unable to speak in certain situations due to fear or anxiety). The Social Service Assessment and Documentation dated 5/23/25 documented Resident #1 was usually understood, usually understands and had moderate cognitive impairment.</p> <p>Resident #2 had diagnoses including morbid obesity, chronic kidney disease and hypothyroidism. The Minimum Data Set (a resident assessment tool) dated 4/1/2025 documented Resident #2 was always understood, always understands and was cognitively intact.</p> <p>Resident #3 had diagnoses including encephalopathy (a disease in which the functioning of the brain was affected), polyneuropathy (a disease process involving a number of nerves), and anemia. The Minimum Data Set, dated [DATE] documented Resident #3 was always understood, always understands and had severe cognitive impairment.</p> <p>Resident #4 had diagnoses including cerebral infarction (stroke), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body). The Minimum Data Set, dated [DATE] documented Resident #4 was usually understood, usually understands and had severe cognitive impairment.</p> <p>Review of the New York State Complaints/Incidents Tracking System Investigative Report received on 6/10/25 at 10:52 AM revealed photographs that were posted on social media sites by Certified Nurse Aide #1, as well as a text message that was sent to the Administrator. The photographs attached to the report revealed heavily soiled, incontinent residents in various stages of undress, with their buttocks and genitalia exposed. The social media post indicated the post was publicly shared 825 times. The report documented that the incident was not submitted by the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility investigation dated 6/11/25 revealed on 6/9/25 social media posts alleged that Resident #1, Resident #2, and Resident #3 did not receive care on 5/25/25 to 5/26/25. The social media posts also showed photographs of facility residents in various states of care. The facility investigation documented the incident was reported to the Buffalo Police Department on 6/12/25, to the State Agency on 6/12/25 and the Office of Professions on 6/12/25.</p> <p>During a telephone interview on 6/12/25 at 9:00 AM, Certified Nurse Aide #1 stated they were a mandated reporter, and they were following the chain of command by reporting to the facility first. They stated they felt filing a complaint with the New York State Department of Health would not help so, they posted the pictures on social media sites of the facility and residents. The pictures had people in them but there were no faces, names or identification, so HIPAA (Health Insurance Portability and Accountability Act) was not broken. The pictures showed that the residents were laying in feces and the linens needed to be changed. Certified Nurse Aide #1 stated because there were no resident faces in any of the pictures there would be no issues related to HIPAA or dignity.</p> <p>During an interview on 6/12/25 at 9:42 AM, Certified Nurse Aide #2 stated the pictures posted on social media contained residents' exposed backside, including their buttocks. Certified Nurse Aide #2 stated Resident #4 was in one of the pictures that was shared on social media.</p> <p>During an interview on 6/12/25 at 9:48 AM, Certified Nurse Aide #3 stated they saw the social media post and Resident #4 was pictured in the post. They stated they knew it was Resident #4 because after taking care of someone so often, they were just able to tell it was Resident #4.</p> <p>During an interview on 6/12/25 at 1:25 PM, the Administrator stated they were aware within an hour of the post on social media that included allegations against the facility as well as pictures of residents laying in their beds. They began an investigation immediately but did not think about the possibility of abuse at the time. Allegations of suspected abuse should be reported within two (2) hours to the State Agency. Further interview at 3:30 PM, the Administrator stated they had not notified the State Agency or the local law enforcement agency at that time.</p> <p>During an observation and interview on 6/12/25 at 3:27 PM, the Director of Nursing was at their computer in their office and the Administrator was on their cell phone. The Administrator stated the Director of Nursing was filing an incident with the State Agency and they were on the phone with the Local Police Department.</p> <p>During an interview on 6/18/25 at 9:00 AM, Social Worker #1 stated if they were to see pictures of undressed residents including their buttocks and genitalia posted on social media, they would report it to the abuse coordinator immediately and file a report against the person who made the post. They stated that was something that could be humiliating and degrading for the residents involved.</p> <p>During an interview on 6/18/25 at 11:10 AM, the Director of Nursing stated the types of abuse include verbal, financial, sexual, physical, mental/emotional and neglect. An example of mental/emotional abuse would include making a resident feel humiliation shame, or embarrassment. The Director of Nursing stated that the social media incident was reported immediately after the recertification team brought it to their attention and questioned if it was abuse. Reporting allegations of suspected abuse was completed by the Director of Nursing, Administrator or Assistant Director of Nursing and should be reported to mitigate and maintain resident safety. Everyone in the facility has the responsibility to ensure the safety of the residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/25 at 11:35 AM, the Administrator stated the day that the incident happened was on 6/9/25, the incident was not seen as suspected abuse but was viewed a dignity concern and was investigated as a dignity concern. Any suspected abuse should be reported within two (2) hours to the State Agency. The incident on 6/9/25 was reported to the State Agency on 6/12/25.</p> <p>During an interview on 6/18/25 at 11:55 AM, the Director of Clinical Operations stated they expected the Director of Nursing or Administrator to report suspected abuse to the State Agency within two (2) hours. They stated that because the pictures that were posted on social media certainly could be humiliating and degrading, the incident should have been reported to the State Agency.</p> <p>10NYCRR 415.4 (b)(2)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review conducted during a Complaint investigation (#NY00383127), the facility did not ensure that all alleged violations of abuse and neglect were thoroughly investigated for four (4) (Resident #1, #2, #3, #4) of four (4) residents reviewed. Specifically, there was a lack of employee and resident interviews and statements to rule out abuse regarding a post on social media containing allegations against the facility and pictures of residents in the state of undress.</p> <p>The finding is:</p> <p>The policy and procedure titled Abuse dated 6/2024 documented allegations/reports of suspected abuse, neglect, mistreatment, distortion, injury of unknown etiology or misappropriation shall be promptly and thoroughly investigated by facility management. The Administrator and Director of Nursing are responsible for investigation and reporting. Initiate the investigative process. The investigation should be thorough with witness statements from staff, residents, visitors and family members who may be interview able and have information regarding the allegation.</p> <p>The policy and procedure titled Investigations, How to Conduct dated 11/2019 documented the aim is to complete the investigation as soon as possible from the day of the incident. The investigator conducts interviews in the following order: The resident(s) involved, obtain a statement (if possible) about what occurred from the resident and complete appropriate nursing assessments. Locate and arrange interviews with the people involved in, or who may have witnessed the incident (i.e. the person who found the resident/patient or to whom the incident was first reported, people who were near the incident scene, the staff member responsible for the care of the resident or patient, the nurse responsible for the unit. This may involve going back 24 hours and interviewing staff on previous shifts (or greater than 24 hours if alleged incident occurred earlier). Witnesses should be interviewed separately, and all provide written statements whenever possible. Collect information (evidence) that is related to the facts and circumstances of the incident being investigated. The information should include who, what, when, where, how and why.</p> <p>Resident #1 had diagnoses including generalized anxiety disorder, major depressive disorder, and selective mutism (a mental health condition where an individual was unable to speak in certain situations due to fear or anxiety). The Social Service Assessment and Documentation dated 5/23/25 documented Resident #1 was usually understood, usually understands and had moderate cognitive impairment.</p> <p>Resident #2 had diagnoses including morbid obesity, chronic kidney disease and hypothyroidism (thyroid disease). The Minimum Data Set (a resident assessment tool) dated 4/1/2025 documented Resident #2 was always understood, always understands and was cognitively intact.</p> <p>Resident #3 had diagnoses including encephalopathy (a disease in which the functioning of the brain was affected), polyneuropathy (a disease process involving a number of nerves), and anemia. The Minimum Data Set, dated [DATE] documented Resident #3 was always understood, always understands and had severe cognitive impairment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #4 had diagnoses including cerebral infarction (stroke), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body). The Minimum Data Set, dated [DATE] documented Resident #4 was usually understood, usually understands and had severe cognitive impairment.</p> <p>Review of the Complaints/Incidents Tracking System Investigative Report received on 6/10/25 at 10:52 AM revealed photographs were posted on social media sites by Certified Nurse Aide #1, as well as a text message that was sent to the Administrator. The photographs attached to the report revealed heavily soiled, incontinent residents in various stages of undress, with their buttocks and genitalia exposed. The social media post indicated the post was publicly shared 825 times.</p> <p>The facility investigation dated 6/11/25 documented on 6/9/25 social media posts alleged that Resident #1, Resident #2, and Resident #3 did not receive care on 5/25/25 to 5/26/25. The social media posts also showed photographs of facility residents in various states of care. Multiple staff (more than ten (10)) reported the social media posts to the Administrator. The investigation included attestations of attempts to contact Certified Nurse Aide #1 for a witness statement, resident dignity interview worksheets, nursing progress notes, Certified Nurse Aide care documentation, and five (5) Certified Nurse Aide witness statements regarding care completed on 5/25/25. The investigation lacked staff witness statements regarding the social media post on 6/9/25. The investigation did not include Resident #4.</p> <p>Review of the Resident Dignity Interview Worksheets dated 6/9/25-6/12/25 documented residents were asked if staff treated them with kindness, spoke to them respectfully, knocked prior to entering their room, listened to them, provided personal care in private, if their belongings and space were treated with care, if they felt comfortable speaking up when something was wrong, and if they felt safe and well cared for. Resident #1 answered yes to all questions and signed the worksheet. There were no follow up notes documented. Resident #2 answered that Certified Nurse Aides sometimes treat them with kindness and that they did not feel safe or well cared for. Under the notes section it was documented care concerns - night shift without any further details. There were no further follow-up notes on the worksheet for Resident #2. Resident #3 answered all of the questions with yes with the exception that sometimes they were not sure staff were listening. There was no follow-up notes documented for Resident #3. There were no specific questions regarding concerns of abuse, use of cell phones, staff taking pictures, or social media on the worksheet. There was no Resident Dignity Interview Worksheet completed for Resident #4.</p> <p>Review of Resident #4's interdisciplinary progress notes dated 6/1/25-6/16/25 lacked documented evidence that Resident #4 or their responsible party was interviewed regarding the social media investigation.</p> <p>Review of the facility staffing sheet dated 5/25/25 documented during the 7 AM-3 PM shift, seven (7) Certified Nurse Aides, three (3) Licensed Practical Nurses, and one (1) Registered Nurse worked on Unit Two (2). During the 3 PM-11 PM shift, six (6) Certified Nurse Aides, three (3) Licensed Practical Nurses and one (1) Registered Nurse Supervisor worked on Unit Two (2). During the 11 PM-7 AM shift, three (3) Certified Nurse Aides and three (3) Licensed Practical Nurses worked on Unit Two (2).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility staffing sheet dated 6/9/25 documented during the 7 AM-3 PM shift four (4) Certified Nurse Aides, two (2) Licensed Practical Nurses, two (2) Registered Nurses, and two (2) Unit Managers worked on Unit Two (2). During the 3 PM-11 PM shift, seven (7) Certified Nurse Aides and three (3) Licensed Practical Nurses worked on Unit Two (2). During the 11 PM-7 AM shift one (1) Certified Nurse Aide, two (2) Licensed Practical Nurses, and one (1) Licensed Practical Nurse Supervisor worked on Unit Two (2).</p> <p>During an interview on 6/12/25 at 1:25 PM, the Administrator stated within an hour of the social media post, about eight (8) staff members in the facility had gone to their office to inform them of the social media post. There were other staff members that had texted or called them. The social media post had occurred on 6/9/25 around 3:00 PM and it was a former employee who was posting the pictures on social media and posting that they were from the facility. The Administrator stated at the time that the staff notified them of the social media post, they immediately started investigating by obtaining Certified Nurse Aide documentation and statements. The Director of Nursing had the investigation, and it was ongoing. The Administrator stated they did not ask the staff if they were able to identify the residents in the post because it was inappropriate and would feel uncomfortable with it. They stated they did not think of the pictures and social media post to be a form of abuse.</p> <p>During a telephone interview on 6/12/25 at 4:00 PM, Resident #4's Responsible Party stated they never received a phone call from the facility regarding pictures posted on social media.</p> <p>During an interview on 6/18/25 at 9:00 AM, Social Worker #1 stated they completed dignity rounds for all residents on Unit Two (2). During the dignity rounds they would go to each resident ask them if they felt comfortable or if they had any concerns with the facility. They used the Resident Dignity Interview Worksheet to complete the dignity rounds and only asked the questions that were on the worksheet. Social Worker #1 stated they had not personally asked any of the residents on the unit if they were ok with their pictures being taken or if they would be ok with their pictures being posted online. They stated they were not aware that the social media post on 6/9/25 contained any resident pictures. Any pictures taken of residents, even if it was just their face, consent needed to be obtained from the resident. They stated that they did not interview any of the families about their feelings at the facility or regarding any social media posts.</p> <p>During an interview on 6/18/25 at 11:10 AM, the Director of Nursing stated the investigation was focused on dignity because it was a dignity concern and not abuse. That included the social workers completing dignity rounds, reviewing Certified Nurse Aide documentation to see if residents received care, and nurses completed skin checks. The Director of Nursing stated they believed they received witness statements from all the Certified Nurse Aides they needed to because they looked at the assignment sheets and had the Certified Nurse Aides who were responsible for care of Resident #1, Resident #2, and Resident #3 on 5/25/25 write statements. The Director of Nursing stated they talked to other staff members about the social media post but never had them write any statements because she had a cheat sheet of who she talked to. When the Director of Nursing was asked what the conversation was between them and their staff regarding the cheat sheet no answer was given. The DON stated the statements from the staff were verbal and the incident was a dignity issue.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/25 at 11:35 AM, the Administrator stated because they did not know who the residents were in the pictures or when the pictures were taken, the investigation was general. Social work spoke with residents themselves and asked if there were any negative interactions with staff or if they felt cared for. The Director of Social Work was the one who reached out to the families and Social Worker #1 completed the Resident Dignity Interview Worksheet. They had looked for any previous grievances regarding resident care but were unable to find any grievances; they relied on the Social Workers' dignity audits. The Certified Nurse Aide Witness statements that were obtained were staff that had worked on the unit through various shifts and since the residents pictured could not be identified, they did not interview all of the Certified Nurse Aides on the unit. The Administrator stated they did not feel it would have been appropriate to interview all of the staff on the unit. They stated they had questioned the staff who had reported the social media post if they were able to identify the residents and they were unable to. The Administrator stated without specific identifiers, the incident was investigated the best they could and as a dignity and respect issue.</p> <p>During an interview on 6/18/25 at 11:55 AM, the Director of Clinical Operations stated their expectation was for the investigation to be done objectively and a full sweep of the unit should have been completed. They stated they thought that the Director of Nursing had spoken to everyone on the unit because they had a cheat sheet that they were working off of. The investigation to rule out abuse should have been started when the Administrator and Director of Nursing became aware of the social media post.</p> <p>During an interview on 6/18/25 at 12:30 PM, the Director of Social Work stated their part of the investigation was assisting in completing dignity rounds with the Resident Dignity Interview Worksheet. If a resident was unable to complete the worksheet, then the responsible party should have been called and it would have been documented in the progress notes.</p> <p>10 NYCRR 415.4(b)(3)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	

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)
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  1014 Delaware Ave Buffalo, NY 14209	
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)		
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review conducted during an Abbreviated Partial Extended survey (Complaint #NY00383127) the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body is responsible and accountable for the Quality Assurance and Performance Improvement program. Specifically, the administration did not ensure implementation of abuse policies and recognize abuse when Certified Nurse Aide #1 took personal photographs of heavily soiled incontinent residents in various stages of undress without their consent, including some with their buttocks and genitalia exposed. The photographs were posted on social media along with text messages and descriptions of the lack of resident care. The findings are:REFER TO: F 600 - Free from Abuse and Neglect F 609 - Reporting Alleged Violations F 610 - Investigate/Prevent/Correct Alleged Violation The policy and procedure titled Abuse, dated 6/2024, documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients by anyone. The facility prohibits any exploitation of the mentally and physically disabled residents in the facility. Mental/emotional abuse is the use of verbal and/or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Mental abuse includes abuse that is facilitated or enabled using technology (smart phones, other personal electronic devices and cameras) that demeans or humiliates the resident, regardless of whether the resident provided consent or the resident's cognitive status. The policy and procedure titled Photography - Still and Video, dated 2/2020, documented in order to ensure resident privacy, to provide optimal resident care, and to foster mutual respect between and among the residents, family and staff, the facility will ban audio or visual recordings of resident encounters, activity of daily living (ADL) assistance, care or procedures by residents, visitors and staff, unless specifically allowed by the applicable procedures or required by state law. 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), use of cellular telephones or any other electronic device is prohibited in resident areas. Protected Health Information should never be stored, shared or accessed on a personal device. Inappropriate use of a cellular device by an employee includes, but is not limited to, photographing or videorecording residents and sharing HIPAA (Health Insurance Portability and Accountability Act) protected information via unsecured networks. Review of a Counseling Memo dated 5/7/25 documented the Director of Nursing was provided counseling that all incidents must be thoroughly investigated to rule out abuse and all investigations must include factual data including witness statements and resident interviews to reach a reasonable conclusion. The Counseling Memo was signed by the Director of Nursing. The Director of Clinical Operations signed as the instructor. During an interview on 6/12/25 at 1:25 PM, the Administrator stated they were aware within an hour of the post on social media that included allegations against the facility as well as pictures of residents laying in their beds. They began an investigation immediately but did not think about the possibility of abuse at the time, only dignity. During a telephone interview on 6/17/2025 at 10:14 AM, the Medical Director stated the facility was the residents' home and even though their physical safety was not affected, their mental safety was intruded on. During an interview on 6/18/25 at 11:10 AM, the Director of Nursing stated the incident that occurred was investigated focused on dignity because it was a dignity concern and not abuse. The Director of Nursing stated an example of mental/emotional abuse would include making a resident feel humiliation shame, or embarrassment. During an interview on 6/18/25 at 11:35 AM, the Administrator stated the day that the incident happened on 6/9/25, the incident was not seen as suspected abuse but was viewed a dignity concern and was investigated as a dignity concern. Any suspected abuse should be reported within two (2) hours to the State Agency. The incident on 6/9/25 was reported to the State Agency on 6/12/25. During an interview on 6/18/2025 at 9:00 AM, Social Worker #1 stated the pictures in the social media post were potentially humiliating and degrading for the residents involved. During an interview on 6/18/25 at 11:55 AM the Director of Clinical Operations stated the pictures</p>		