STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335638	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Center for Rehabilitation and Nursing	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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review conducted during a Complaint investigation (2606688) completed on 11/12/2025, the facility did not allow the resident and resident's legal representative to obtain a copy of the resident's medical records or any portion thereof upon request and 2 working days advance notice to the facility for one (1) (Resident #2) of three (3) residents reviewed for medical record access. Specifically, Resident #2 submitted a written request for their medical records to be released to their Health Care Proxy on 08/04/2025 and the facility never released their records. The finding is:The policy titled Release of Information, revised 9/2019, documented residents may initiate a request to release information contained in their records and charts to anyone they wish. Such requests will be honored only upon the receipt of a written, signed, and dated request from the resident or representative. A resident has access to their records (excluding weekends or holidays) upon the resident's written or oral request within 24 hours. A resident may obtain photocopies of their records by providing the facility with at least forty-eight (48) hours (excluding weekends and holidays) advanced notice of such request. A fee may be charged for copying services. Resident #2 had diagnoses that included Carbapenem Resistant Enterobacteriaceae infection (CRE-bacterial infection resistant to most antibiotics), malignant neoplasm of rectum (rectal cancer), and colostomy status (surgical connection of the bowel to the skin surface). The Minimum Data Set (a resident assessment tool) dated 08/05/2025 documented Resident #2 understood, understands, and was cognitively intact. Review of the Authorization for Release of Health Information Pursuant to HIPPA (Health Insurance Portability and Accountability Act) revealed Resident #2 completed and dated the form on 08/04/2025. The Authorization for Release of Health Information Pursuant to HIPPA included the release of information to Resident #2's Health Care Proxy.Review of an email correspondence to Medical Records from Risk Management on 08/05/2025 at 1:16 PM, documented ok to release medical record request once the Director of Nursing has reviewed the records. Review of an email correspondence from Medical Records to the prior Administrator #2 on 08/12/2025 at 11:14 AM, documented a request to review Resident #2's record. During an interview on 10/30/2025 at 2:28 PM, the Administrator #1 stated they were not aware of any medical record requests from Resident #2. They stated Medical Records should have a record of the request if one was made. They stated they would expect the process of releasing medical records to take less than twenty-four (24) hours. During an interview on 10/31/2025 at 2:56 PM, Medical Records stated that for medical records to be released the resident or resident representative must complete a HIPPA (Health Insurance Portability and Accountability Act) form. Once the form is completed it is sent over to Risk Management to review, prior to release of the requested medical records. They stated communication with the facility's Risk Management is completed via email. Once they received the go ahead from Risk Management, they print copies of the medical record and email them to the Director of Nursing to review prior to them being uploaded to a flash drive or being mailed out to the requestor. Medical Records stated Resident #2 requested the release of their medical records on 08/04/2025; the form was emailed to Risk Management on 08/05/2025; and approved to be released by Risk Management, once the Director of Nursing reviewed the records, on 08/05/2025. Medical Records stated they did not email a copy of the medical records requested to be reviewed for Resident #2 until 8/12/2025 to the Director of Nursing #2 and the prior Administrator #2. Medical Records stated they were not sure why there was a delay in forwarding the medical records for Resident #2, I was off or doing other work. They stated the Director of Nursing #2 was no longer employed at the facility during that time, so they forwarded the email to the prior Administrator #2. They stated once it was emailed to the prior Administrator #2 it was out of their hands until they were told that it was ok to release the medical records as requested by Resident #2. They stated they had no clue if the prior Administrator #2 looked at the medical records forwarded to them, they never got an email back from the Administrator #2 to release the records. Medical Records stated Resident #2's medical records were never released as requested and they did not follow up with the prior Administrator #2 to see if they should send the records. Medical Records stated they were not familiar with the facility's policy on releasing medical records and they should have been. Medical Records stated it was important for medical record requests to be sent as requested so the residents know what is going on, it's their information. Medical Records stated they were unable to locate the invoice for the medical records Resident #2 requested.During a telephone interview on 11/04/2025 at 10:42 AM, prior Administrator #2 stated once requested medical records are reviewed by the Director of Nursing, they would be released via a thumb drive or paper copy

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review conducted during an Abbreviated Survey (Complaint #2656144), the facility failed to protect residents from verbal and mental abuse by staff for one (1) (Resident #1) of six (6) residents reviewed for abuse. Specifically, on 10/29/2025, it was observed that Certified Nurse Aide #2 yelled at Resident #1 in a harsh, demeaning tone for urinating on themselves and their surroundings. Certified Nurse Aide #2 then verbally threatened the resident they were going to get moved to another floor. After the verbally abusive encounter, Resident #1 was tearful and appeared saddened. Using the reasonable person concept, as referenced in the Centers for Medicare and Medicaid Services Psychosocial Outcome Severity guide, it was determined psychosocial harm occurred that is not Immediate Jeopardy. The finding is:The facility policy titled 'Abuse' revised 07/18/2025 documented the facility prohibits the mistreatment, neglect, and abuse of residents by anyone. Verbal abuse was oral language that willfully incudes disparaging and derogatory terms, to the resident, or within their hearing distance, to describe resident, regardless of their age, ability to comprehend or disability. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation including but not limited to harassing or yelling, intimidation, threatening or isolation and deprivation of goods and services. 1. Resident #1 had diagnoses including encephalopathy (disease disturbing brain function), obstructive hydrocephalus (fluid buildup in the brain), and intracerebral hemorrhage (bleeding within the brain). The Minimum Data Set (a resident assessment tool) dated 07/18/2025 documented Resident #1 was severely cognitively impaired, was sometimes understood, and sometimes understands others. Resident #1 was frequently incontinent of urine and exhibited no behaviors. The Comprehensive Care Plan initiated 04/21/2025 documented Resident #1 had difficulty communicating with others. The plan documented interventions to anticipate resident needs; monitor for physical/nonverbal indicators of distress, communicate with the resident regarding capabilities; introduce self and explain care; and to use communication techniques to enhance interactions. The Comprehensive Care Plan also documented that Resident #1 was incontinent of bladder and required staff assist with self-care. Review of Kardex (guide used by staff to provide care) Report dated 10/29/2025, documented that Resident #1 be provided peri-care after each incontinent episode; check and provide toileting care every two (2) to four (4) hours as tolerated and was dependent on two (2) or more staff.During an observation on 10/29/2025 from 4:03 PM to 4:12 PM, Certified Nurse Aide #2 was in hallway outside Resident #1's room walking away appearing frustrated and stated loudly, Resident #1 does this all this time, peeing everywhere. This is annoying! They cannot do anything about this. This just makes me want to go home. At this time, Resident #1 was observed in their room laying across their bed facing the window with their legs hanging off the side of the bed. The resident was wearing a hospital gown and an incontinence brief. Their incontinence brief was pushed down from the waist and the resident was observed urinating on themselves, their bed sheets and on the floor. Certified Nurse Aide #2 walked back into Resident #1's room yelling at Resident #1, They are going to send you right to four (4)! Resident #1 was heard to say something (inaudible) to Certified Nurse Aide #2 in which they then replied, I do not want to hear it! Certified Nurse Aide #2's tone of voice was harsh, hostile, impatient and dismissive. Certified Nurse Aide #2 picked the floor mat up from the floor next to the bed and tossed it towards the doorway. Certified Nurse Aide #1 then entered the resident's room to assist Certified Nurse Aide #2 with care and closed the door. While the door to Resident #1's room was closed Certified Nurse Aide #2 was overheard saying, They are going to send you to the fourth floor. During an interview on 10/29/2025 at 4:13 PM, Certified Nurse Aide #2 stated they were frustrated. They stated they had been blamed in the past for Resident #1 peeing everywhere and had been suspended. They stated the second floor was a rehab floor and that they didn't sign up for this. They stated Resident #1 had dementia and did not belong on the rehab floor. Certified Nurse Aide #2 stated they believed Resident #1 had some common sense in their head and should not be peeing everywhere. They further stated, Imagine if you had to deal with that. Certified Nurse Aide #2 stated that was the first time they had raised their voice to Resident #1. The surveyor's observation was reported to Social Worker #1 at 4:15 PM as the social worker was on their way to the Resident #1's room to deliver a message to the resident. During an observation on 10/29/2025 at 4:15 PM, Certified Nurse Aide #2, Social Worker #1 and the Surveyor entered Resident #1's room. Certified Nurse Aide #2 stated to Resident #1, Have I ever yelled at you before? Resident #1 would not look at or speak to Certified Nurse #2. During an interview on 10/29/2025 at 4:24 PM, Registered Nurse Supervisor #1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review conducted during an Abbreviated survey (Complaint #2587167) 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 one (1) (Resident #3) of three (3) residents reviewed. Specifically, allegations of resident abuse were not reported no later than 2 hours to the New York State Department of Health. The finding is: A policy titled Abuse revised 07/18/2025 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 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. Resident #3 was admitted to the facility diagnosis include Cerebral Palsy (a group of disorders affecting a person's movement, posture, and muscle tone due to permanent, non-progressive brain damage that occurs before, during or after birth), intellectual disability (a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills), and dysphagia (difficulty swallowing, which can involve problems with liquids, solids, or saliva). The Minimum Data Set (a resident assessment tool) dated 09/25/2025 documented Resident #3 was cognitively severely impaired, rarely / never understood by others and rarely / never understands. The undated comprehensive care plan documented that Resident #3 had impaired cognition related to intellectual disability, had limited physical mobility with impaired movements, impulse disorder with intermittent explosive disorder requiring assistance with activities of daily living. Review of e-mails provided by Administrator #1 from Resident #3's Health Care Proxy Agent dated 09/28/2025 through 10/06/2025 revealed the following: -On 09/30/2025 at 08:08 PM an email sent to the Administrator #1 from Resident #3's Health Care Proxy Agent documented the lady who shower (Resident #3) is (Certified Nurse Aide #12) yelled '(Resident #3) you want to puke your getting cold shower this teach you a lesson' and said '(Resident #3) your on my last nerve so maybe you not getting fed will teach you stop puking every time I feed you' and step on (Resident #3's) right foot saying 'I hope it hurts ya' - that's a form of abuse. Review of an undated, untitled document identified by Administrator #1 as their summary of the facility's actions related to the e-mails received from Resident #3's Health Care Proxy Agent, revealed the summary did not document evidence the facility reported the abuse allegations to New York State Department of Health as required. During an interview on 11/04/2025 at 11:15 AM Director of Nursing #1 stated they were not aware of an allegation of abuse documented in an e-mail on 9/30/2025 from the Health Care Proxy Agent to Administrator #1. Director of Nursing #1 read the e-mail dated 09/30/2025 at 8:08 PM and stated the e-mail documented an allegation of verbal, mental, and physical abuse to Resident #3 and it should have been reported to the New York State Department of Health within 2 hours as required and it was not. During an interview on 11/12/2025 at 11:45 AM, Administrator #1 stated they received multiple e-mails from the Resident #3's Health Care Proxy Agent between 09/28/2025 through 10/01/2025 and they inadvertently missed the allegation of abuse documented in the e-mail dated 09/30/2025 at 8:08 PM. They stated they should have read the e-mails more closely to discern there was allegations of abuse and the allegations should have been reported to the New York State Department of Health within 2 hours as required and it was not. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review conducted during an Abbreviated survey (Complaint #2587167) the facility did not ensure that all alleged violations of abuse were thoroughly investigated for one (1) (Resident #3) of three (3) residents reviewed. Specifically, the Administrator received an allegation of abuse through an e-mail on 09/30/2025, at 8:08 PM from Resident #3's Health Care Proxy Agent that was not investigated. The finding is: A policy titled Abuse revised 07/18/2025, 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. A policy titled Investigations, How to Conduct revised 11/2019 documented the facility has designed and implemented processes to enable it to come to a resolution, after thoroughly investigating grievances, accidents, incidents. Losses, thefts, allegations or other means in order to determine appropriate actions that can be taken to correct the situation and prevent further recurrences. If an incident occurs on off-hours and is a potential injury or possible abuse, neglect mistreatment or exploitation, notify Director of Nursing and Administrator-on-call immediately upon initiation of investigation. Investigator conducts interviews with people involved in, or who may have witnessed the incident. Resident #3 was admitted to the facility diagnosis include Cerebral Palsy (a group of disorders affecting a person's movement, posture, and muscle tone due to permanent, non-progressive brain damage that occurs before, during or after birth), intellectual disability (a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills), and dysphagia (difficulty swallowing, which can involve problems with liquids, solids, or saliva). The Minimum Data Set (a resident assessment tool) dated 09/25/2025 documented Resident #3 was cognitively severely impaired, rarely / never understood by others and rarely / never understands. The undated comprehensive care plan documented that Resident #3 had impaired cognition related to intellectual disability, had limited physical mobility with impaired movements, impulse disorder with intermittent explosive disorder requiring assistance with activities of daily living. Review of e-mails provided by Administrator #1 from Resident #3's Health Care Proxy Agent dated 09/28/2025 through 10/06/2025 revealed the following: -On 09/30/2025 at 08:08 PM an email sent to the Administrator #1 from Resident #3's Health Care Proxy Agent documented the lady who shower (Resident #3) is (Certified Nurse Aide #12) yelled '(Resident #3) you want to puke your getting cold shower this teach you a lesson' and said '(Resident #3) your on my last nerve so maybe you not getting fed will teach you stop puking every time I feed you' and step on (Resident #3's) right foot saying 'I hope it hurts ya' - that's a form of abuse. Review of an undated, untitled document identified by Administrator #1 as their summary of the facility's actions related to the e-mails received from Resident #3's Health Care Proxy Agent, revealed the summary did not document evidence the facility was investigating abuse allegations. During an interview on 11/04/2025 at 11:15 AM, Director of Nursing #1 stated Administrator #1 did not share the e-mail dated 09/30/2025 at 8:08 PM with them or inform them of an allegation of abuse. Director of Nursing #1 read the e-mail dated 09/30/2025 at 8:08 PM and stated they should have been informed of the allegation of abuse and an investigation should have been completed to determine if abuse had occurred. They stated their investigation should have included statements from the accused staff, other potential witnesses/staff, and they would have suspended the accused staff pending their investigation results. During an interview on 11/12/2025 at 11:45 AM, Administrator #1 stated they received multiple e-mails from the Health Care Proxy Agent between 09/28/2025 through 10/01/2025 and they inadvertently missed the allegation of abuse documented in the e-mail dated 09/30/2025 at 8:08 PM. They stated they should have read the e-mails more closely to discern there was an allegation of abuse, and an investigation should have been initiated, and it was not. 10 NYCRR 415.4(b)(3)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review conducted during an Abbreviated survey (Complaint #2624947) the facility did not ensure that each resident received adequate supervision and assistive devices to prevent accidents for one (1) (Resident #4) of four (4) residents reviewed for accidents. Specifically, Resident #4 was not provided with total assistance of two (2) staff members for bed mobility as per the comprehensive plan of care resulting in the resident falling from their bed, sustaining a multilayered facial laceration (deep gash in multiple tissue layers) to their left cheek and swelling to their left eye. Resident #4 was transferred to the hospital and required surgical repair of the laceration. This resulted in actual harm to Resident #4 that is not Immediate Jeopardy. This finding is: The policy and procedure titled 'Activities of Daily Living (ADL) Care and Support' revised 11/06/2025 documented that activities of daily living (ADL) care and support will be provided for residents who are unable to carry out activities of daily living independently in accordance with the resident's needs, personal preferences, and individualized plan of care that includes but not limited to bed mobility, transfers, and toileting. Resident #4 had diagnoses that included cerebral infarction (stroke), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) of the right side. The Minimum Data Set (a resident assessment tool) dated 07/14/2025 documented Resident #4 was rarely understood, rarely understands others and had severe cognitive impairment. The Comprehensive Care Plan dated 07/07/2025 documented Resident #4 required assistance with self-care and mobility and was at risk for falls. Interventions documented the resident was dependent on two (2) or more staff to roll left and right in bed; dependent on two (2) or more staff for toileting hygiene; and staff were to provide assistance per the resident needs and therapy recommendations. The Kardex Report (a guide used by staff to provide care) dated 08/08/2025 documented Resident #4 was dependent on two (2) or more staff for lying to sitting on the side of bed, rolling left and right, sitting to lying, and toileting hygiene. The Initial Event Documentation V-12 form completed by former Registered Nurse Manager #2 dated 08/08/2025 documented that at 2:40 PM, Resident #4 fell out of bed while they received care which caused an open laceration to their left cheek. Resident #4 was transferred to the hospital for further evaluation and treatment. The Attending Physician and Resident #4's family were notified. The hospital Emergency Department Provider Note dated 08/08/2025 documented Resident #4 required two (2) person assist at the nursing home to help roll them, today they had one (1) staff member roll them and they accidently rolled out of bed. The Provider note documented on physical exam Resident #4 had sustained a large laceration to the left side of their cheek from the left side of nose extending to the superior (upper) portion of the upper lip, they had conjunctival hemorrhage (broken blood vessel on the white part of the eye) present to the lateral (to the side) aspect of left eye. There was evidence of possible corneal (outer clear layer of the eye) abrasion, and mild swelling and erythema (redness of the skin) overlying the left eye. Resident #4 required a Computed Tomography Scan (CT scan -type of imaging test that uses detailed x-rays to detect diseases and injuries) of head, neck, chest, abdomen/pelvis to be completed. A facial trauma consult was required to reconstruct the laceration. The hospital Ear, Nose and Throat (ENT) Provider Consult note dated 08/09/2025 documented Resident #4 had a six (6) centimeter complex laceration to left midface extending from nasal (nose) base inferior(lower) to medial canthus (inner corner where upper and lower eyelids meet near the nose) down through the nasolabial fold (creases that extend from the sides of nose to corner of mouth). The Ear, Nose and Throat Provider Consult note documented that Resident #4's facial laceration was repaired in a multilayered fashion at bedside (deep layer was closed and the skin layer was closed). Recommendations included but were not limited to: treat facial pain symptomatically; apply Polysporin (antibiotic ointment) twice a day to the repaired laceration; Keflex (antibiotic) for 10 days; sutures to be removed in 7-10 days. During a telephone interview on 10/30/2025 at 10:41 AM, Former Registered Nurse Manager #2 stated on 08/08/2025 they were notified by a certified nurse aide (could not recall who) that Resident #4 had fallen from their bed. Former Registered Nurse Manager #2 stated Resident #4 was found to have a laceration to the left side of their face with a large amount of bleeding. They assessed the resident, applied pressure to the wound and called the ambulance. They stated the Medical Provider, Director of Nursing #2 (former), and Resident #4's responsible party were notified. Former Registered Nurse Manager #2 stated they completed the Initial Event Documentation form and Change in Condition form in the medical record and collected staff statements. Former Registered Nurse Manager #2 stated Resident #4 was dependent on staff for all care and required a two (2) person assist for bed mobility. Former Registered Nurse Manager #2 stated they interviewed