

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335640	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Delaware Oaks Center for Rehabilitation and Nursi		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 Delaware Avenue 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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a Complaint Investigation (2598732) during the Standard survey completed on 09/19/2025, the facility failed to protect residents from resident-to-resident sexual abuse for one (1) (Resident #12) of three (3) residents reviewed. Specifically, Resident #12 was touched inappropriately by Resident #51 and both residents lacked the ability to consent. The finding is: The policy titled Prevention, Investigation & Reporting Resident Abuse, Mistreatment, Injury of Unknown Source, Neglect & Misappropriation of Resident Property Effective 5/2024 and last reviewed 7/2024 documented that it was the facility's policy to prevent sexual abuse, and documented sexual abuse was defined as non-consensual sexual contact of any type with a resident. Resident #51 had diagnoses which included dementia, depression, and type 2 diabetes mellitus. The Minimum Data Set (a resident assessment tool) dated 08/29/2025 documented Resident #51 was severely cognitively impaired, was usually understood and usually understands others. The comprehensive care plan revised on 08/29/2025 documented that Resident #51 was at risk for being a victim due to their inability to understand their surroundings related to cognitive impairment, dementia, their dependence on others and their impaired mobility. Resident #12 had diagnoses including aphasia (a language disorder that affects a person's ability to communicate), Alzheimer's disease with early onset, and Post Traumatic Stress Disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). The Minimum Data Set, dated [DATE] documented Resident #12 was severely cognitively impaired, was rarely/never understood and sometimes understands others. The comprehensive care plan revised on 08/29/2025 documented that Resident #12 was a risk of being a victim due to their inability to understand their surroundings, related to cognitive impairment and dementia. Resident #12 was severely cognitively impaired and not able to make decisions for themselves. The documented interventions dated 5/30/2024 included to provide support and ensure resident was free from abuse. The resident exhibited behaviors such as hallucinations, delusions, wandering, aversion with hands on care, and medical treatments. Documented interventions initiated on 3/31/24 included to distract and offer pleasant diversions, determine cause of behavior and remove resident, medications as ordered, psych evaluations as needed, document behaviors, ensure safe comfortable environment. Resident #61's Minimum Data Set, dated [DATE] documented they were cognitively intact. The Complaint/Incident Investigation Report 2598732 submitted by the facility to the Internet Quality Improvement and Evaluation System on 08/23/2025 at 1:15 PM documented that on 08/22/2025 at 5:34 PM, Resident #61 reported they observed Resident #12 standing in front of Resident #51, at which time Resident #51 had placed their left hand under Resident #12's shirt and rubbed Resident #12's left breast. Review of the Nursing Home Investigative Report submitted by the facility on 09/01/2025 at 8:33 PM documented that there was reasonable cause to believe that abuse occurred. Review of the facility Accident/Incident form dated 08/22/2025 at 5:34 PM documented that Resident #61 reported to facility staff that they had witnessed Resident #12 standing in front of Resident #51, who was seated in their wheelchair and that Resident #51 had their left hand under Resident #12's shirt and was rubbing Resident #12's left breast. During an observation on 09/16/2025 at 9:51 AM, Resident #51 was in bed, and was not able to be interviewed. During an observation on 09/15/2025 at 10:56 AM, Resident #12 was dressed and resting on their bed and was not able to be interviewed. During an interview on 09/18/2025, Resident #61 stated they witnessed Resident #51 touch Resident #12 in an inappropriate manner. Resident #12 was standing close Resident #51, making noises, and Resident #51 was running their hands all over Resident #12. They reported this immediately to the Administrator. Review of an Employee Statement Form completed by Certified Nurse Aide #3 and dated and signed 09/10/2025 documented that on 08/22/2025 they witnessed Resident #51 put their hand up Resident #12's bra. A call was placed to Certified Nurse Aide #3 for interview without success. During a telephone interview on 09/19/2025 at 11:44 AM, Certified Nurse Aide #1 stated they worked during the evening shift on 08/22/2025 and Resident #51 had been brought back from an activity and was seated in their wheelchair near the elevator. Resident #12 had kept approaching #51, staff would intervene. Resident #51 was then moved to a different location. During an interview on 09/19/2025 at 9:00 AM, Registered Nurse #2 Unit Manager stated on 8/22/2025 Resident #12 was especially attention-seeking with Resident #51. Resident #51 was moved to another floor. The intervention immediately implemented was to keep Resident #12 away from male residents (within arm's length) and staff education. Resident #12 was seen by the</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review conducted during Complaint investigation (2598732) during the Standard Survey completed on 09/19/2025, the facility did not ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse, to the administrator and to other state officials (including to the State Survey Agency) for two (2) (Residents #12 and #51) of three (3) residents reviewed. Specifically, the Administrator was notified of an allegation of resident-to-resident abuse and it was not reported to the State Agency within the required time frame. The finding is: Refer to F 600 Freedom from Abuse and Neglect The policy titled Prevention, Investigation & Reporting Resident Abuse, Mistreatment, Injury of Unknown Source, Neglect & Misappropriation of Resident Property Effective 5/2024 and last reviewed 7/2024 documented that it was the facility's policy to prevent abuse and any suspected or actual violation required immediate reporting to the Administrator, Director of Nursing, Social Worker, Nursing Supervisor or House Charge Nurse on duty. Immediate action was to be taken to report any incident to the New York State Department of Health. It further documented the New York State Department of Health required immediate reporting of suspected or actual abuse to the Administrator of the facility and, when required by law or regulation to the New York State Department of Health via the Health Commerce System Network Incident Reporting Form or the Abuse Hotline. The New York State Department of Health must be contacted about alleged abuse if someone tells you they saw abuse. When reasonable cause is established that abuse may have occurred, the incident must be reported to the New York State Department of Health within 24 hours. The investigation does not need to be completed before reasonable cause is established. The Complaint/Incident Investigation Report 2598732 submitted by the facility to the Internet Quality Improvement and Evaluation System on 08/23/2025 at 1:15 PM documented that on 08/22/2025 at 5:34 PM, Resident #61 reported they observed Resident #12 standing in front of Resident #51, at which time Resident #51 had placed their left hand under Resident #12's shirt and rubbed Resident #12's left breast. During an interview on 09/18/2025, Resident #61 stated they witnessed Resident #51 touch Resident #12 in an inappropriate manner. Resident #12 was standing close to Resident #51, making noises, and Resident #51 was running their hands all over Resident #12. They reported this immediately to the Administrator. During an interview on 09/18/2025 at 11:45 AM, the Administrator stated that Resident #61 reported what they had observed to them immediately. The Administrator stated they immediately called the nurse supervisor (Registered Nurse #5) and instructed them to go to the unit to intervene. The Administrator stated they believed the nurse supervisor informed the Director of Nursing of the allegation and was instructed to start an investigation. The Administrator stated the abuse allegation should have been reported to the State Agency immediately and thought the Director of Nursing had completed the reporting. During an interview on 09/18/25 at 12:32 PM, the Director of Nursing stated they knew these types of abuse allegations needed to be reported to the New York State Department of Health immediately and no later than two (2) hours after an allegation was made. They stated they had not reported this on time, because they had not completed their investigation and had not determined if it had happened. 10 NYCRR 415.4(b)(4)</p>		