

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335663	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Safire Rehabilitation of Southtown, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Dorrance Avenue Buffalo, NY 14220	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review conducted during an Abbreviated survey (complaint #2717679), the facility failed to keep the resident's environment free from accidents. Specifically, one (1) (Resident #1) of three (3) residents reviewed for accidents was transferred via mechanical lift by Certified Nurse Aide #1, without assistance of another staff member, and the resident fell out of the sling sustaining a laceration on their leg. The findings include: The policy and procedure titled Resident Transfer Using a Total Mechanical Lift, dated 11/03/2017, documented two (2) or more caregivers must be present and assisting at all times during the use of a total mechanical lift, and there must be a minimum of two (2) caregivers interfacing with their hands on the resident and the total mechanical lift. Resident #1 was admitted to the facility with dementia and type 2 diabetes mellitus. The Minimum Data Set (a resident assessment tool), dated 01/30/2026, documented Resident #1 usually understands others and usually was understood by others; was cognitively impaired; and needed assistance of two (2) staff members for transfers. The care plan profile, dated 01/14/2026, documented Resident #1 was dependent on two (2) staff members for transfers with a gait belt (a safety device worn around a patient's waist to assist with mobility and prevent falls during transfers and walking). Interdisciplinary progress note, dated 01/14/2026 at 9:23 PM, documented Registered Nurse Supervisor #1 was called to Resident #1's room. Resident #1 was noted to be on their left side near the mechanical lift with a six-inch laceration on their left leg. Resident #1 was subsequently sent to the emergency room. Interdisciplinary progress note, dated 01/15/2026 at 1:12 AM, documented the sling and the mechanical lift were examined by Registered Nurse Supervisor #1 and the Director of Nursing, and were found to be in good working order. The investigation of Resident #1's fall, dated 01/21/2026, documented Certified Nurse Aide #1 used the mechanical lift by themselves and stated they could not find another staff member to assist them with the transfer. Certified Nurse Aide #1's personnel file documented they received training for mechanical lift transfers of residents during their orientation with the facility. During an observation and interviews on 04/29/2026 at 8:15 AM, Resident #1 was transferred from their bed to their chair by Certified Nurse Aide #2 and Certified Nurse Aide #3, and there were no issues with the transfer. Certified Nurse Aide #2 stated there should always be two (2) staff members when they transfer with a mechanical lift for the residents' safety. Certified Nurse Aide #3 stated they worked on 01/14/2026 and they did not recall Certified Nurse Aide #1 asking them for help. Certified Nurse Aide #3 further stated there were two (2) aides on each hallway working that shift. During an interview on 04/29/2026 at 9:05 AM, Registered Nurse Supervisor #1 stated Certified Nurse Aide #1 admitted to them they transferred Resident #1 by themselves. Additionally, Registered Nurse Supervisor #1 stated they recalled Resident #1 was found on the floor near the mechanical lift and saw the laceration after they put Resident #1 into the bed. During an interview on 04/30/2026 at 11:00 AM, Resident #1's physician stated they did not believe it was harm because the resident did not receive stitches, instead, they received Steri-Strips (adhesive tape that are used for small, shallow cuts). Resident #1's physician further stated the resident was not admitted to the hospital and their baseline did not change. During an interview on 04/30/2026 at 11:30 AM, the Director of Nursing stated they expected (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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Certified Nurse Aides to always use two (2) staff members before they transferred anyone with a mechanical lift. The Director of Nursing further stated that you need two (2) staff members for resident safety. During an interview on 04/30/2026 at 12:04 PM, the Regional Clinical Educator stated Certified Nurse Aide #1 received training for mechanical lift transfer. The Regional Clinical Educator further stated there should be a minimum of two (2) people to transfer a resident in a mechanical lift. During an interview on 04/30/2026 at 12:14 PM, the Administrator stated they expected staff to find other staff members to transfer a resident with a mechanical lift. The Administrator further stated Certified Nurse Aide #1 should have asked someone for help before they attempted to transfer a resident with a mechanical lift, and there was enough staff, including a nursing supervisor, that could have helped Certified Nurse Aide #1. During an interview on 04/30/2026 at 12:28 PM, Certified Nurse Aide #1 stated they did transfer Resident #1 by themselves. Certified Nurse Aide #1 further stated they could not find anyone to help them transfer Resident #1. Additionally, Certified Nurse Aide #1 stated they knew they should not have transferred Resident #1, but Resident #1 kept asking to put them to bed. Certified Nurse Aide #1 stated it was the end of their shift at 10:00 PM, and they did not want to leave the resident for the next shift to take care of them. Furthermore, Certified Nurse Aide #1 stated they never intended to hurt Resident #1, and they felt awful that Resident #1 was hurt. Certified Nurse Aide #1 concluded by stating they were terminated from the facility after this incident. New York Codes, Rules, and Regulations (NYCRR) 415.12(h)(1)</p>		