STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335663	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Safire Rehabilitation of Southtown, L L C	300 Dorrance Avenue Buffalo, NY 14220

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during complaint investigations (NY00353449/786213) conducted during a Standard survey completed on 12/09/2025, the facility did not ensure sufficient staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility did not have sufficient nurse staffing on a 24-hour basis to adequately care for residents' needs. This involves Residents #2, #4, #7, #22, #41, #55, #67, #72, #77, #82.The findings are:Reference: F 561 Self DeterminationThe policy titled Nursing Department Staffing dated 12/28/2017, documented the facility maintained adequate staffing on each shift to ensure that their residents needs and services were met. Certified Nursing Assistants (CNAs) were available to provide the needed care and services of each resident as outlines on the resident's comprehensive care plan. The facility would provide sufficient numbers of licensed and non-licensed personnel (Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides) on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. The policy titled Emergency Staffing Call-in for Off Duty Personnel, revised 06/28/2019, documented in case of an emergency or disaster to meet minimum staffing and resident care needs, off-duty personnel shall be recalled to the facility as needed. The Nursing Administrator staff would be on-call to cover the emergency such as excessive licensed nurse call offs, weather emergencies, etc. The Administrator would contact department heads to contact ALL staff to come into the facility as assist the nursing staff with non-care interventions during emergency situations.The Dear Administrator letter 23-11 dated 06/30/2023 sent to nursing home administrators documented starting 04/01/2022 nursing homes were required to maintain at minimum daily average staffing hours equal to 3.5 hours per resident per day (HPRD) by a certified aid (CNA) and a licensed practical nurse (LPN) or registered nurse (RN). Out of such 3.5 hours, no less than 2.2 HPRD shall be provided by a certified nurse aide, and no less than 1.1 HPRD shall be provided by a Licensed Practical Nurse or Registered Nurses. The Facility assessment dated [DATE] documented the facilities staffing plan: one (1) Registered Nurse per regulation, eight (8) hours a day, seven (7) days a week and two (2) Licensed Practical Nurses in the building for all three (3) shifts. That applied to weekends as well. Minimum staffing numbers for staff providing direct care were as follows: -Director of Nursing Registered Nurse one (1) full time days, -Assistant Director of Nursing one (1) full time days, -one (1) Registered Nurse Minimum Data Set Coordinator full time days, -two (2) Licensed Practical Nurses (Monday - Friday days) (census dependent) including weekends ,-two (2) Charge Nurses (Monday - Friday days) (census dependent) including weekends , -two (2) Charge Nurses (Monday - Friday evenings) (census dependent) including weekends,-two (2) Charge Nurses (Monday - Friday nights) (census dependent) including weekends. The above does not include 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM supervisors.-7:00 AM to 3:00 PM shift: four (4) Certified Nurse Aides (Monday - Friday days) (census dependent) including weekends.-3:00 PM to 11:00 PM shift: three (3) Certified Nurse Aides (Monday - Friday days) (census dependent) including weekends.-11:00 PM to 7:00 AM shift: three (3) Certified Nurse Aides (Monday - Friday days) (census dependent) including weekends.1. The (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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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility Daily Census Report by unit dated 10/31/2025 documented the following:-Blue unit, the total resident census was 38.-Green unit, the total resident census was 38.-Yellow unit, the total resident census was 40.Review of the facility nursing schedule titled Nursing Department 24-hour staffing sheet dated 10/31/2025 documented the following:-Blue unit, the 3:00 PM - 11:00 PM shift had one Certified Nurse Aide that left at 10:00 PM; one Licensed Practical Nurse 3:00 PM to 11: PM, and one Registered Nurse 3:00 PM - 7:00 PM. -Yellow unit, the 3:00 PM - 11:00 PM shift had zero Certified Nurse Aides listed and one Licensed Practical Nurse 3:00 PM - 11:00 PM.-Green unit, the 3:00 PM - 11:00 PM shift had two Certified Nurse Aides, one left at 9:00 PM: one Licensed Practical Nurse 3:00 PM - 7:00 PM and one Licensed Practical Nurse 7:00 PM - 11:00 PM.There was one Registered Nurse Nursing Supervisor 3:00 PM - 11:00 PM, two (2) Licensed Practical Nurse Nursing supervisors 7:00 PM - 11:00 PM (one training), and one Registered Nurse Assistant Director of Nursing called in to assist from 8:45 PM to 10:45 PM.A review of Resident Council minutes from October 2025 documented residents complained that on the evening shift on October 31st, 2025, there was no staff. Residents requested to invite Registered Nurse #6 (former) Assistant Director of Nursing to attend the next council meeting.A review of Resident Council Department Response Form dated 11/05/2025 documented Resident #106 complained they did not get their shower on the evening of 10/31/2025 and other residents complained there was no staff. Registered Nurse #6 (former) Assistant Director of Nursing documented a response dated 11/11/2025 that Resident #106 was correct, there were several call ins that evening; they personally came in to assist at 8:30 PM and put residents on the yellow unit to bed, signed by Registered Nurse #6 Assistant Director of Nursing on 11/11/2025.During an interview on 12/02/2025 at 9:23 AM, Resident #41 stated on the night of 10/31/2025 staffing was horrible in the facility, residents were afraid to ring for assistance because no staff was there. Resident #41 stated usually staff would come around and do rounds, but they did not. When the residents found out how many staff were in the facility, the residents just waited until someone came around to help them. Additionally, Resident #41 stated about 50 percent (%) of the staff working the evening shift (3:00-11:00 PM) were staff from the morning shift (7:00 AM-3:00 PM), sometimes even more. Wait times for call lights to be answered was typically a half hour in the morning and almost an hour on the evening shift, and weekend evenings were even worse.During a telephone interview on 12/04/2025 at 1:32 PM, Licensed Practical Nurse #13 stated they worked the evening shift (3:00 PM - 11:00 PM) on 10/31/2025 and stated they did work short staffed, as holidays tended to be a little shorter. They stated they try to help the aides, when possible, everyone tried to work as a team; some residents may have not gotten to bed before 11:00 PM, but they got to bed eventually.During a telephone interview on 12/0402025 at 1:32 PM, Certified Nurse Aide #3 stated they worked the evening shift (3:00 PM - 11:00 PM) on 10/31/2025 and there were multiple call offs. They stated there were two aides, including themself on the [NAME] unit, and one aide on the Blue unit, and no aides on the Yellow unit. They were eventually floated down to the Yellow unit and assisted Registered Nurse #6 (former) Assistant Director of Nursing with putting residents to bed. Certified Nurse Aide #3 stated residents had been touched, and rounds had not been completed for residents on the yellow unit when they floated down there, so they had to hustle and bustle to get residents toileted and into bed. During an interview on 12/04/2025 at 12:03 PM, Certified Nurse Aide #10 stated they worked a double (7:00 AM - 9:00 PM) on 10/31/2025 because there was no staff for the evening shift (3:00 PM - 11:00 PM). Certified Nurse Aide #10 stated they worked on the [NAME] unit with Certified Nurse Aide #3 and two nurses, and all their work was completed on the unit when they left at 9:00 PM. There was one aide on the Blue unit, and no aides the Yellow unit. Certified Nurse Aide #10 stated Certified Nurse Aide #3 went to the Yellow unit around 9:00 PM to assist with putting residents to bed. Additionally, Certified Nurse Aide #10 stated showers were not able to be completed that night. They added there have been times in the past that they worked that short, and a lot of morning staff would work doubles to help.During an interview on 12/05/2025 at 9:55 AM, Staffing Coordinator stated a lot of staff called off on 10/31/2025, but that was after they left for the day. The nursing supervisor tried to call people (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in, and nurses helped with aide duties.During an interview on 12/05/2025 at 3:15 PM, the Director of Nursing stated they were out of town during the week of 10/31/2025 so they were unable to come in when there were multiple call offs in the facility, or else they would have come in to help. They stated Registered Nurse #6 Assistant Director of Nursing (former) came in and helped put people to bed on the Yellow unit, and all the nurses helped when they could. They have the right to call off. The Director of Nursing stated it was not brought to their attention that showers were unable to be completed on 10/31/2025, or any other day, due to short staffing. They would have expected that information to have been relayed to them. During an interview on 12/09/2025 at 10:10 AM, the Administrator stated the emergency minimum staffing for each shift would be three nurses and three aides to the building, and they were aware of one day recently where the facility did not meet their minimum numbers for the evening shift, 10/31/2025. The Administrator stated they came in to assist with non-nursing duties on 10/31/2025 during the evening. Additionally, the Administrator stated they were aware that some residents did complain about staffing on 10/31/2025, but the staff worked as hard as they could with what they had, but they were unable to recall if showers were able to be completed.2a. During multiple observations on 12/02/2025 at 9:43 AM, 12/03/2025 at 8:56 AM, and 12/04/2025 at 9:06 AM, Resident #7 was in their bed, in their pajamas.During an interview on 12/01/2025 at 1:08 PM, Resident #7 stated they have expressed to staff, including Licensed Practical Nurse Unit Manager #1 they wanted to be out of bed by 7:45 AM, but was told staff had to change residents who were not changed all night. Resident #7 stated staff do not usually get them up until 11:00 AM, sometimes later. Resident #7 stated I do not get to choose what time I get up, and that was not right.During a telephone interview on 12/04/2025 at 5:11 PM, Licensed Practical Nurse #5 stated they worked the night shift (11:00 PM to 7:00 AM) and were aware Resident #7 wanted to be up by 7:45 AM. The resident used to be on the early riser list due to needing assistance in the dining room, for safety reasons, and because their preference was to be up by 7:00 AM. Licensed Practical Nurse #5 stated sometimes staff could not get to Resident #7 before the shift was over because there was not enough staff. Sometimes there was only one aide, or none, so they would complete aide rounds on top of completing their nursing duties, sometimes they would have one aide float between two units to help.During an interview on 12/05/2025 at 2:59 PM, Licensed Practical Nurse Unit Manager #1 stated they were aware that Resident #7 wanted to be out of bed by 7:00 AM. They stated staff should be following Resident #7's care profile preferences, but because of low staffing they could not always honor the resident's choices.During a follow up interview on 12/05/2025 at 4:40 PM, the Director of Nursing stated they expected staff to honor Resident #7s preferences for getting up at 7:00 AM, and if there was not adequate staff to do so on the night shift, then they should pass it along to the morning shift so that Resident #7 could be their priority. If there was an emergency staff may not have been able to honor their preference, they would expect staff to document that.2b. During an interview on 12/02/2025 at 9:37 AM, Resident #82 stated they had not had a shower in three weeks, since they admitted to the facility; they were itchy, and it bothered them. During an interview on 12/05/2025 at 12:10 PM, Certified Nurse Aide #3 stated there was not enough staff on the evening shift to give Resident #82 an actual shower because they were a two assist, so they gave them a bed bath on their shower days. They stated if there was not enough staff then they were not able to give all their showers, they have asked nurses to help but they were just as busy.During an interview on 12/08/2025 at 8:38 AM, Licensed Practical Nurse Charge Nurse #3 stated they could put Resident #82 into the shower with a Hoyer (mechanical lift requiring two people assist) into the shower chair, it just depended on how many staff they had that day. The nurses needed to help the aides when it came to situations like that. Licensed Practical Nurse Charge Nurse #3 stated the unit can be very busy and the staff may not always be able to get to showers.3. Resident/family interviews on 12/01/2025 revealed the following:9:48 AM, Resident #4 stated there was not enough staff in the facility to care for the residents daily; they wait at least a half hour at minimum for their call light to be answered, it did not matter what time of day it was. Resident #4 stated the night prior they rang (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	their call light for a pain pill at 11:30 PM and staff did not answer it until 5:30 AM.10:07 AM, Resident #135 stated they must wait around 45 minutes for staff to answer their call light on a regular basis, and on the weekends the wait time was even longer. Resident #135 stated there have been days when there was not enough staff to get them out of bed or administer their nightly medications.11:57 AM, Resident #128 stated they were mostly independent and getting an aide to help you was like pulling teeth. They have had their call light on from 9:00 AM to 3:00 PM without anyone answering it or checking on them. They stated their showers were on Fridays, they would gather their things for the shower, but no one would ever come. They stated they had not had a shower in three months, it was supposed to be on the 7:00 am to 3:00 PM shift.12:58 PM, Resident #72's family member stated there was a delay in care due to lack of staff in the facility, especially on the weekends. There was typically one nurse and two aides for the whole floor.1:08 PM, Resident #7 stated they wait a half hour or longer for their light to be answered on a regular basis. There were times when they would be on the toilet, ring their bell, staff would tell them they had to get another aide to help them, and then take even longer to return. Staff have even shut off the call light and never returned.3:09 PM, Resident #67 stated there were not enough aides in the facility, especially on the weekends and holidays. Staff call off, the shifts were not filled and there was a delay in care being provided when that occurred.Resident/family interviews on 12/02/2025 revealed the following:9:18 AM, Resident #2 stated the facility staffing was worse on weekends, if they put their call light on, they would wait hours for it to be answered. Normal wait time was between a half hour to one hour; it took a long time for staff to come and change their incontinent briefs.9:30 AM, Resident #82 stated when they ring the bell and call for help, it takes an hour, sometimes an hour and a half, across all shifts, for anyone to answer. There was a delay in getting staff into complete care. Between shifts nobody answered lights. They do not even come in to tell you they will be back and do not return.10:55 AM, Resident #22's family member stated they come and visit every weekend, and staffing always seems very light. There was one time they were visiting, and their family member rang the bell because they had soiled themselves and the light was not answered for thirty minutes.11:45 AM, Resident #55's family member stated the facility was understaffed and staff were over worked. Their family member had fallen twice and was constantly in the same saturated brief for extended periods of time due to understaffing.3:51 PM, Resident #77 stated the facility could use more staff, sometimes it took three (3) hours for staff to answer your call light, but typically it was a half hour. The weekends were especially bad. Staff say they will be with you in a minute but do not come back for an hour then you're told the same thing.Additional staff interviews revealed the following:12/03/2025 at 11:27 AM, Certified Nurse Aide #13 stated staffing was awful; they're usually working with two or three Certified Nurse Aides on the unit, and for 40 people it was too much. Certified Nurse Aide #13 stated even when there were four aides to the unit, they would each have ten residents. On their assignment, out of those ten residents, nine were two assists and five residents needed assist to eat. So, it was very difficult to get to everyone and do everything that they needed in a timely manner. Certified Nurse Aide #13 stated the weekends staffing were even worse and residents were left for hours without getting changed at times. The nurses were usually working with one nurse per unit so they cannot assist the aides with care, passing trays, or feeding. Tee aides were skipping their breaks to make sure residents were changed and fed, and then were yelled at for skipping their breaks.12/04/2025 at 9:11 AM, Licensed Practical Nurse #12 stated when there was only one nurse to the unit for 40 residents, they were not able to get their work done. If they were down aides that made it even more difficult, because they try to help the aides but can barely do that.12/04/2025 at 1:32 PM, Certified Nurse Aide #3 stated all shifts were short staffed occasionally. A general complaint from residents on the evening shift was that showers were not done and residents were not gotten out of bed, the staff just try to reassure the residents that things will be done as soon as they can get to it, pass things on to the next shift if they were not able to complete them, but they were not sure if things were completed after they left or not.During an interview on 12/05/2025 at 9:55 AM, the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staffing Coordinator stated if there were multiple call offs, they would contact the staffing agency they utilized to see if someone was able to come in. On holidays they purposely overstaff the facility in case staff did not show up.During an interview on 12/05/2025 at 3:15 PM, the Director of Nursing stated they expected there to always be an adequate number of staff in the facility to provide the care to residents in accordance with the plan of care. If there were call offs, they would try to have other staff come in to fill the open positions.During an interview on 12/09/2025 at 10:10 AM, the Administrator stated some staff have said they had issues getting their work done even when there was full staff, but it had not been conveyed to them that they were having trouble completing care. The Administrator stated the staff should relay their issues to their supervisor or department heads, who would bring it to their attention.10 NYCRR 415.13(a) (1) (i-iii)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review conducted during a Standard and Complaint (#2655733) survey completed on 12/09/2025, the facility did not provide food and drink that was palatable, attractive, and at a safe and appetizing temperature for three (Green Unit, Yellow Unit, and Blue Unit) of three test trays. Specifically, food and beverages during meals were served at suboptimal temperatures and were not palatable. Residents #4, #7, #12, #41, #81, #82, #88, #92, #106 and #136 were involved.The findings are:The facility policy and procedure titled Food Preparation and Service dated 06/26/2018 documented food service employees shall prepare and serve food in the manner that complies with safe food handling. The danger zone for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods must be maintained at 40 degrees or below or at 136 degrees or above. During a Resident Council Meeting with survey staff on 12/02/2025 at 11:28 AM, Residents #7, #41, #88, #92, #106, and #136 all stated food was served cold for all meals, was bland with no taste, and portion sizes were too small. Additionally, all resident council members stated they received too much pasta and was always added into the meal.During an interview on 12/01/2025 at 7:57 AM, Resident #12 stated the food was hit or miss and was always served lukewarm, vegetables were either cold or mushy, or the food was dry.During an interview on 12/01/2025 at 9:54 AM, Resident #4 stated the food was disgusting, had no taste and was served cold even when the plate was covered. Further interview on 12/02/2025 at 9:23AM, Resident #4 stated their breakfast was cold and pancakes tased like rubber.During an interview on 12/01/2025 at 1:18 PM, Resident #7 stated meals were served cold and at times they received burnt grilled cheese They stated on Thanksgiving they were served a slice of deli meat turkey with gravy that was cold, salty and gross.During an interview on 12/02/2025 at 9:47 AM, Resident #82 stated meals were served cold, there was no variety, received too many saucy foods and pastas for lunch.During a lunch meal observation on 12/04/2025 the first dietary cart arrived on the [NAME] Unit at 12:14 PM and the second cart arrived at 12:24 PM. All the lunch trays from the [NAME] Unit were passed to the resident's by 12:41 PM. The Food Service Director was not present for the test tray and the temperatures were taken by the state surveyor using a digital thermometer at 12:44 PM. The temperatures and taste were as follows:-Sliced turkey, 105.1 degrees Fahrenheit - tasted salty, pale in color, unappealing, not palatable.-Mashed potatoes, 122.7 degrees Fahrenheit - lacked flavor, warm but not hot.-California vegetable mix, 105.8 degrees Fahrenheit - cool to taste, watery, mushy, flavorless.-Milk, 51.3 degrees Fahrenheit - was cool but not cold-Orange drink, 57.7 degrees Fahrenheit- cool to taste but not cold, flavor was weak and tasted watered downDuring an interview on 12/04/2025 at 1:00 PM, Resident #4 stated their lunch was terrible and had thrown most of it out. They stated it was cold; vegetables were watery and lacked flavor. The grilled cheese was burnt and not edible.During a lunch meal observation on 12/04/2025 the dietary carts arrived on the Yellow Unit at 12:29 PM. All lunch trays from the Yellow Unit were passed to the resident's by 12:40 PM. The test tray temperatures were taken by the Food Service Director at 12:45 PM using the facility's thermometer. The temperatures and taste were as follows:-Sliced turkey, 100 degrees Fahrenheit - single slice of turkey on plate, light beige in color, unappealing, cool to taste, and had no flavor.-California vegetable mix, 116 degrees Fahrenheit - cool to taste, bland and no flavor-Milk, 48 degrees Fahrenheit- tasted cool but was not cold-Orange drink, 58 degrees Fahrenheit - cool to taste but not coldDuring an interview on 12/04/2025 at the time of the test tray, the Food Service Director stated that the temperatures for the turkey and vegetables were low, they would have expected the hot foods to be served between 130-140 degrees and cold foods were to be served below 40 degrees Fahrenheit. The Food Service Director stated the turkey was not served with gravy per resident preference and were unaware of any cold food complaints from the resident council.During an interview on 12/04/2025 at 1:00 PM, Resident #92 stated they did not want the turkey, requested the (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	alternate meal (hamburger) which was served warm, they stated the vegetables were bland, needed seasoning and could have been warmer.During an interview on 12/04/2025 at 1:02 PM, Resident #7 stated they did not eat the turkey, it was not appetizing and looked gross. They stated they did not like the texture of the mashed potatoes, they ate some of the vegetables and drank their boost.During a lunch meal observation on 12/04/2025 the first dietary cart arrived on the Blue Unit at 12:30 PM and the second cart arrived at 12:51 PM. All lunch trays for the Blue Unit were passed to the residents by 12: 58 PM. The test tray temperatures were taken by the Food Service Director at 1:03 PM using the facility's thermometer. The temperatures and taste were as follows:-Sliced turkey, 110 degrees Fahrenheit - flavorless, cool to taste, unappealing in color.-Brussel sprouts, 120 degrees Fahrenheit - mushy, lukewarm-Milk, 56 degrees Fahrenheit - cool to taste but not cold-Orange drink, 58 degrees Fahrenheit- cool to taste, flavor was weak and tasted watered downDuring an interview on 12/04/2025 at the time of the test tray, the Food Service Director stated they would expect the hot temperatures to be higher and the cold temperatures to be lower. They stated the turkey should have been served hotter and the brussels sprouts needed to be a little warmer. The Food Service Director stated there was no concern with food borne illness because the food had not been sitting out for four (4) hours.During an interview on 12/08/2025 at 2:24 PM, the Director of Nursing stated they were not aware of any cold food complaints made by the residents. They stated there was a resident food committee that met monthly but did not attend. The Director of Nursing stated they were usure what the exact temperatures should be to serve hot and cold foods but would be concerned with food borne illness if not maintained at the proper temperatures. 10 NYCRR 415.14 (d) (1) (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review conducted during the Standard survey completed on 12/09/2025, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This affected one (1) of one (1) Main Kitchen and one (1) (Green Unit) of three (3) Nourishment Rooms. Specifically, the Main Kitchen had issues with opened undated, outdated, and/ or unlabeled foods. [NAME] restraints were not being worn during food preparation. There was a water leak from plumbing in the dishwash area and the window air conditioning unit in the food preparation area was dust laden. In addition, a Nourishment Room refrigerator contained undated and/ or unlabeled food.The findings are:The policy titled Food Receiving and Storage, issued 06/26/2018 documented foods shall be received and stored in a manner that complies with safe food handling practices. Food Services, or other designated staff, will maintain clean food storage areas at all times. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Food items and snacks kept on the nursing units must be maintained as indicated: all food items must be placed in the refrigerator located at the nurses' station and labeled with a use by date, all foods belonging to residents must be labeled with resident's name, the item, and the use by date, beverages must be dated when opened and discarded after twenty-four (24) hours, other opened containers must be dated and sealed or covered during storage. The policy titled Refrigerators and Freezers, revised 02/27/2020 documented the facility will ensure safe refrigerator and freezer maintenance, temperatures and sanitation, and will observe food expiration guidelines for all refrigerators on the nursing units and in the Food Services Department. The Dietary Service Department personnel will surface clean the nourishment refrigerators on the nursing units daily and discard any outdated items. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened, and all food/ liquids dated past 24-hours should be discarded. Dietary Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates.The policy titled Food Preparation and Service, issued 06/26/2018 documented dietary staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.The policy titled Foods Brought by Family/ Visitors, revised 02/19/2020 documented food brought into the facility by visitors and family is permitted. Family members and visitors are requested to inform nursing staff of their desire to bring foods into the facility. All food is to be brought to the nursing station. Food brought by family/ visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility prepared food. Perishable foods must be stored in re-sealable containers that are labeled with the resident's name, the item, and the use by date. Beverages must be dated when opened and thrown out in 24 hours. Other food items must be dated and sealed or covered during storage and thrown out in 48 hours. The dietary staff will discard perishable foods every 24 hours on or before the use by date.The policy titled Sanitization, issued 06/26/2018 documented the food service area shall be maintained in a clean and sanitary manner. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair. Kitchen surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. The Food Service Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas.1.Observation in the Main Kitchen on 12/01/2025 between 7:35 AM and 8:20 AM revealed the following:-The reach-in cooler contained a small half-eaten dessert with no name or date, a zippered lunch box, a half-full ten (10) ounce container of Mexicali dip with no name, date, or manufacturer's date, about one (1) quart of chicken broth dated 11/21/2025, and about one (1) cup of cheese dip with (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Safire Rehabilitation of Southtown, L L C	300 Dorrance Avenue Buffalo, NY 14220

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	no date. This cooler contained a small bin labeled Employee that was full of food. During an interview on 12/01/2025 at 7:40 AM, the Food Service Director stated there was a bin in the reach-in cooler for employees' food, but the bin had been superseded. Employees' food was in the rest of the cooler too, and it should not be. The Food Service Director stated they were unsure why the chicken broth was in this cooler, but it needed to be thrown out because of its date.-The walk-in cooler contained a tray of approximately ten (10) vanilla pudding cups with no date on cups or tray, a tray of various nourishments including pudding cups, cereal cups, and wrapped sandwiches with no date on individual items or tray, four (4) wrapped sandwiches on the rack with no date, a tray of fifteen (15) wrapped sandwiches with no date on sandwiches or tray, approximately five (5) pounds of sliced ham dated 11/18/2025, approximately four (4) pounds of egg salad dated 11/25/2025, approximately two (2) pounds of sliced turkey labeled Turkey 4 Sandwiches dated 10/24/2025, approximately one and a half (1 1/2) pounds of sliced turkey in a clear plastic container with no date, eight (8) ounces of chicken broth dated 11/22/2025, approximately twenty (20) hot dogs in a bucket dated 11/21/2025 or 11/24/2025 (unable to decipher handwriting), tray of cups of pickles and cups of cranberry with no date on cups or tray, approximately 40 ounces of a tomato and cucumber salsa dated 11/26/2025, a bucket of twenty (20) individual cups of diced tomato and cucumber with no date on the cups or the bucket, a tray of approximately twenty (20) sandwiches on the top shelf with no date on the sandwiches or the tray, approximately forty (40) croissants stored in two (2) bags with no date on the bags, approximately twenty (20) hot dogs in clear plastic wrap with no date and two (2) raw hamburgers in clear plastic wrap with no date.During an interview on 12/01/2025 at 7:45 AM, Dietary Aide #2 stated when foods were placed on trays in the walk-in cooler, there should be a date on the tray. They also stated they personally just placed the tray of vanilla puddings in this cooler this morning and they did not write the date on the tray.During an interview on 12/01/2025 at 7:55 AM, the Food Service Director stated trays of food in the walk-in cooler should have the date written on them. They stated no food item was kept longer than three (3) days, except breads could go up to five (5) days. If there was no date on the bags of croissants, they will get thrown out. All items in this cooler that are more than three (3) days old must be thrown out. The Food Service Director also stated the opened packs of hot dogs and hamburgers should have been labeled with the date they were removed from their original packaging. Additionally, on 12/01/2025 at 8:30 AM, the Food Service Director stated it was everyone's responsibility to ensure foods were labeled with the date they were made and to add a date to new packaging when food was removed from its original packaging. They stated checking dates on food was not a documented task, but they were personally on the lookout all the time for dates on foods, along with the Food Service Supervisor. At this time, the Food Service Director also stated the sliced turkey dated 10/24/2025 must have been mislabeled because they were certain it was from November and not October. -The window air conditioning unit had a visible coating of dust on its louvers and clumps of dust on the windowsill below. Additional observation revealed the window air conditioning unit was located approximately two (2) feet from the sink, approximately two feet from the oven, and approximately four (4) feet from the tray line.During an interview on 12/01/2025 at 10:40 AM, the Maintenance Director looked at the air conditioning unit and stated it needed to be cleaned. They opened the front louvers and determined there was no filter inside. They stated since there was no filter, cleaning it would be the responsibility of the Kitchen staff, not the Maintenance staff. During an interview on 12/01/2025 at 10:55 AM, the Food Service Director stated the window air conditioner needed to be cleaned, but they were not sure whose responsibility it was. -A bucket of water was observed under the plumbing to the right of the automatic dishwasher. During an interview on 12/01/2025 at 10:40 AM, the Maintenance Director ran the water from the food grinder and observed the water dripping from the plumbing into the bucket. They stated they were not aware of this leak.During an interview on 12/01/2025 at 11:00 AM, the Food Service Director stated they put a work order about the water leak in the facility's automated maintenance work order system back in August.During an interview on 12/01/2025 at 3:05 PM, the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Maintenance Director stated they did receive a work order request for a Kitchen plumbing leak back in August, and they repaired it, and the current leak was a different issue.2. A continuous observation on 12/04/2025 from 11:56 AM to 12:52 PM of the Kitchen tray line for the lunch service revealed that [NAME] #1 was not wearing a beard cover to cover their facial hair while preparing residents' lunch trays.During an interview on 12/04/2025 at 12:52 PM, [NAME] #1 they stated they should have been wearing a beard guard, so their hair does not go into the food.During an interview on 12/04/2025 at 12:55 PM, Dietary Aide #1 stated they would expect staff with facial hair to be wearing a beard guard, so their hair does not go into the food.During an interview on 12/04/2025 at 1:03 PM, the Food Service Director stated they did not realize [NAME] #1 was not wearing a beard guard. They stated they have beard guards for facial hair and would expect staff to wear the beard guards, so hair does not get into the food.3.Observation in the [NAME] Unit Nourishment Room on 12/01/2025 at 8:55 AM revealed the following: -A sign on the refrigerator read, 4/24/24 Attention all staff any staff food or drink found in the refrigerator will be discarded immediately. -Another sign on the refrigerator read, This refrigerator is for resident use only! All items must be labeled with resident's name and date! Audits will be conducted spontaneously! Any items found unlabeled or over 3 days old will be discarded. Any employee belongings will be discarded as well.-The refrigerator contained a pizzeria box with chicken nuggets inside with no name or date, iced tea in a pitcher with no date, an opened box of orange juice with approximately 24 ounces remining and not dated when opened, garlic bread wrapped in tin foil with no name or date, a plate of food covered with tin foil that was labeled with a resident's name and no date, and a restaurant style foil container of ravioli with no name or date. There was also a bag labeled with a resident's name and room number and Don't Touch. Inside the bag was macaroni and cheese and ham. There was no date on the outer bag or inner container. The refrigerator also contained two foil containers of beans labeled with a resident's name and Don't Touch and dated 11/27/2025.During an interview on 12/02/2025 at 9:15 AM, the Food Service Director stated food in Nourishment Room refrigerators should be kept for a maximum of three (3) days. They stated resident families were typically good about labeling the foods that they brought in, but residents themselves were not as good. Residents needed to label and date their own foods before putting them in the Nourishment Room refrigerator or ask for assistance if they needed it. The Food Service Director stated if they discovered food in a Nourishment Room refrigerator that had a name without a date, they would personally talk to that resident, educate them about the importance of properly labeling their food, and add the date to their food if they could recall the date. If the resident was unable to recall the date the food was brought in, it would be discarded.During an interview on 12/04/2025 at 3:00 PM, the Director of Nursing stated food in the Nourishment Room refrigerators always needed to be labeled with the resident's name and date. It must be used within three (3) days for safety, to avoid potential foodborne illness. They stated the Dietary staff was responsible for checking the refrigerators in the Nourishment Rooms, but Nursing staff would also discard food if they noticed it was over three (3) days old.10 NYCRR 415.14(h)Subpart 14-1: 14-1.43, 14-1.110(d), 14-1.140

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review conducted during a complaint investigation (Complaint #'s 786244 and 2655733) during the Standard survey completed on 12/09/2025, the facility did not ensure that there were housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for three (3) (Yellow, Blue and Green) of three (3) resident units. Specifically, there were stained privacy curtains in resident rooms (first floor-Yellow unit); dirty shower room floors/walls, ceiling tiles in disrepair, and a toilet seat in disrepair (first floor-Blue unit); oxygen (02) concentrator filters covered with thick grey dust, hair in shower drain, personal resident items in shared bathroom and shower room; ripped and stained mattress; lack of paper towels for staff and resident use, and malodorous odors in resident areas (second floor-Green unit). Residents #2, #5, #67 and #72 were involved. The findings are: The policy titled Cleaning and Disinfection of Resident- Care Items and Equipment, dated 02/01/2017, documented resident-care equipment, including reusable items and durable medical equipment would be cleaned and disinfected to current CDC (center for disease control) recommendations for disinfection and the OSHA (occupational safety and health administration) bloodborne pathogens standard. Semi-critical items consisted of items that may come in contact with mucous membranes or non-intact skin (respiratory therapy equipment) Such devices should be free from all microorganisms. Reusable items were cleaned and disinfected or sterilized in between residents (durable medical equipment) according to manufacturer's instructions. Infection control compliance rounds would be conducted to ensure compliance with infection control standards and oversight of resident specific personal care items. The Nursing Department was responsible for replacing and labeling residents personal care items with room number and date distributed; items included soap, body wash, lotion, etc. The undated policy titled Maintenance Service documented maintenance service shall be provided to all areas of the building, grounds, and equipment. The Maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel included maintaining the building in good repair and free from hazards, providing routinely scheduled maintenance service to all areas. The Maintenance Director was responsible for developing and maintaining a schedule of maintenance services to assure that the buildings, grounds, and equipment were maintained in a safe and operable manner. The undated facility document titled Housekeeping Procedure Manual-Cleaning Resident & Non-Resident Areas documented the purpose was to improve sanitation and ensure the highest level of cleanliness throughout the facility, to control cross contamination, the spread of bacteria and infection and to maintain the outward appearance of the facility. Daily cleaning of resident rooms consisted of cleaning all vertical and horizontal surfaces, including the bed. Complete detailed room cleaning was performed monthly, and each housekeeper was responsible for one (1) per day. A complete room cleaning included disinfecting furniture and any beds located within the room and the removal, washing; bed washing and disinfection included to inspect the mattress for any damage, if any was discovered, notify supervisor; rehanging of cubicle curtains within the room at least semi-annually or as needed. Showers were cleaned to maintain cleanliness, sanitation, optimum levels of safety, to control the spread of infection and bacteria to minimize unpleasant odors and maintain the outward appearance of the facility. Safety precautions included to report any damage or problems to supervisor immediately. Cleaning a shower room included inspecting the area and picking up any large pieces of trash, linen, clothing, etc.; wash walls, windowsills and ledges with disinfecting solution, clean shower stall, shower curtains, and partitions; sweep floor, then damp mop floor, including inside of stall showers and against all walls. The job description of a housekeeper documented they were to implement required housekeeping procedures in an efficient, cost-effective manner meeting all federal, state, and local requirements while providing a safe environment for the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. Specific job functions: maintained resident room by cleaning restrooms, walls, baseboards, doors, ceilings, mirrors, dusting, washing windows, removing trash, etc., dust and cleaned all furniture and fixtures in the resident rooms, day rooms, nursing stations, and shower rooms using various cleaners. Review of the undated (formal name) Healthcare oxygen concentrator manual documented the air filter prevented dirt, dust, and lint from entering the unit. The manual further documented the air filter and connector should be cleaned at least once a week using the following steps: remove the air filter located on the back of the unit; wash in a solution of warm water and dishwashing detergent; rinse thoroughly with warm tap water and towel dry. The manual documented to clean the concentrator exterior cabinet as needed using a damp cloth or sponge with a mild household cleaner and wipe it dry. First Floor: Intermittent observations and interviews revealed the following: YELLOW UNIT- Resident Rooms: -12/03/2025 at 11:40 AM, privacy curtain in Resident room [ROOM NUMBER] at the door was discolored a brownish-gray color. The privacy curtain in the middle of the room was soiled with multiple dark marks on the lower half that appeared to be food or beverage splatter.-12/04/2025 at 9:00 AM, privacy curtain in Resident room [ROOM NUMBER] had was soiled with a black debris. During an interview on 12/03/2025 at 11:40 AM, the Maintenance Director stated both privacy curtains in Resident room [ROOM NUMBER] needed to be washed. During an interview and observation on 12/04/2025 at 9:00 AM, Housekeeper #1 stated that the privacy curtain in Resident room [ROOM NUMBER] was washed but they were probably stained. They stated they thought maintenance takes care of the curtains but, they were not sure. They stated that it was not homelike. During an interview on 12/05/2025 at 10:18 AM, Maintenance Director stated there was only one spare privacy curtain for the entire facility to swap out for stained curtains, and they could not find any others to replace the stained curtains. They plan on ordering more but not sure when that would be. Laundry was supposed to wash the soiled curtains but can only do one at a time. BLUE UNIT-Resident Room, and Shower Room -12/03/2025 at 12:30 PM, the toilet seat in the bathroom of Resident room [ROOM NUMBER] was loose; when pushed, the toilet seat moved approximately five (5) inches side to side. During an interview on 12/03/2025 at 12:30 PM, Resident residing in room [ROOM NUMBER] stated the toilet seat in their bathroom was loose and it bothered them. -12/04/2025 at 12:21 PM, the shower stall had approximately 10 (ten) small black fuzzy balls of what appeared to be hair on the floor, pink/orange debris on the wall and floor where they meet approximately half an inch high up the shower wall; the ceiling tile above the shower stall where the circular light fixture was centered in, had a three by five foot tan circular area with a dark brown ring around it, that was bowing, damp, and soft to the touch. During an observation and interview on 12/04/2025 at 12:23 PM, Certified Nurse Aide #13 stated the shower stall should have been cleaned by the certified nurse aide after they gave a shower. Someone forgot to clean it up, but they should have. They stated they thought maintenance cleaned the shower stalls because they never saw housekeeping in the shower rooms. They stated the ceiling tile in the shower stall had been bowing and discolored for about four (4) months, maintenance was aware; it made them nervous to give a shower in that area because the tile could fall on a resident's head. During an observation and interview on 12/04/2025 at 12:28 PM, Registered Nurse #3 Unit Manager stated a certified nurse aide had not been back to clean up after they gave a shower yet; the shower stall could use some scrubbing and housekeeping was responsible for cleaning the shower stall walls and floors. They stated the ceiling area in the shower stall had been fixed previously because there was a plugged drain in the shower room directly above that one and it leaked down into the shower room. Registered Nurse #3 Unit Manager then touched the ceiling tile and stated they did not know the ceiling tile was damp and would let maintenance know. During an observation and interview on 12/04/2025 at 12:35 PM, The Regional Plant Operation Director poked the ceiling tile in the shower room and their index finger went directly through the tile, stated it was damp; they exited the shower room, and stated to the Administrator, it was old; they were going to check the shower room on the unit directly above. During a follow up interview on 12/04/2025 at 12:45 PM, The Regional Plant Operations Director and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintenance Director stated the shower room was dry upstairs, so the leak may have been from the night prior or earlier that morning; they pulled a large clog of hair out of the drain upstairs and the drain started working again. During an observation and interview on 12/04/2025 at 8:52 AM, the Housekeeping/Laundry Supervisor stated the certified nurse aides were responsible for cleaning the shower stall and equipment after use. They stated they would expect the housekeeping staff to mop the shower room floors daily but had to find out who cleaned the wall tiles. Second Floor: Intermitted observations and interviews revealed the following:GREEN UNIT- Resident Rooms, Shower Room -12/01/2025 at 9:18 AM, Resident #2 was observed lying in bed and receiving oxygen at three (3) liters per minute via nasal (nose) cannula administered through an oxygen concentrator; the outside of the oxygen concentrator was dusty and the sponge like filter to the back of the concentrator was covered in thick grey dust. -12/01/2025 at 9:23 AM, Resident room [ROOM NUMBER] bathroom was without paper towels and there were four (4) unlabeled, used eight (8) ounce bottles of body wash on the sink ledge. -12/01/2025 at 9:35 AM, Resident #5 was observed lying in bed, receiving oxygen at two (2) liters per minute via nasal (nose) cannula administered through an oxygen concentrator. The outside of the oxygen concentrator was observed to be dusty and the sponge like filter to the back of the concentrator was covered in thick grey debris. -12/01/2025 at 10:20 AM, Resident #67's air mattress outer waterproof cover was ripped and peeling revealing a large, brown/red stained area. -12/02/2025 at 8:44 AM, Resident room [ROOM NUMBER]'s shared bathroom floor was tacky, with a malodorous urine odor, grout lines between tiles surrounding toilet were dirty and dark black in color. There were two (2) unlabeled, used, eight (8) ounce bottles of body wash and one (1) uncapped, unlabeled, used, four (4) ounce bottle of body lotion on the sink ledge remained. Additionally, there were no paper towels present. -12/02/2025 at 8:52 AM, Resident #2's oxygen concentrator and filter remained soiled.-12/03/2025 at 8:30 AM, Resident #2's oxygen concentrator remained soiled and unchanged.-12/03/2025 at 10:37 AM, Resident #67's air mattress remained stained and in disrepair.-12/03/2025 at 11:11 AM, shower room stall had four (4), unlabeled, used, eight (8) ounce bottles of body wash present on hand railing; clump of hair on the floor in the corner of the stall and hair covering the drain; the floor had debris and candy wrappers on floor and in the shower stall. -12/03/2025 at 11:27 AM, personal items remained in room [ROOM NUMBER]'s shared bathroom, the floor remained tacky, the malodorous urine odor remained, grout remained black in color.-12/03/2025 at 4:40PM, Resident #5's oxygen concentrator remained dust laden.-12/04/2025 at 8:52 AM, Resident #5's oxygen concentrator remained dust laden. During an interview on 12/03/2025 at 10:37 AM, Resident #67 stated their air mattress did not hold air when they were lying in it, and it alarmed all the time. They stated it had been like that for 2-3 weeks and that maintenance had looked at it, but did not do anything about it; it was ripped and unsanitary. During an interview on 12/03/2025 at 11:29 AM, Certified Nurse Aide #12 stated body wash and lotion should be labeled by whoever was placing them in the resident's room for infection control purposes. During an observation and interview on 12/03/2025 at 11:45 AM, Housekeeper #4 stated Resident room [ROOM NUMBER]'s bathroom smelled like urine. The grout was a mess and that the urine odor absorbed into the floor. It should not smell like that and was not homelike. They stated facility floor techs do not go into resident rooms/bathrooms, they just clean the hallway floors on the unit. Housekeeper #4 stated they do not carry paper towels on their housekeeping carts. Only the Housekeeping/Laundry Supervisor, Maintenance Director and Administrator have access to the paper towels. They stated if paper towels were available, they replace them as needed. They stated it was unsanitary not to have access to paper towels when hands were washed. Additionally, they stated there were eight (8) resident rooms without paper towels on the [NAME] Unit that day. During an interview on 12/03/2025 at 11:29 AM, Certified Nurse Aide #12 stated there has been a shortage of paper towels, toilet paper accessible to them and they have had to give residents boxes of tissues to use as toilet paper. They stated they go to different areas, rooms to use paper towels to dry their hands. They stated they tell housekeeping if they were present; and has reported it to the Housekeeping/Laundry Supervisor and told they were (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out of stock. During an observation and interview on 12/03/2025 at 11:57 AM Resident #72's bathroom did not have paper towels available, and the toilet paper was on the edge of the sink. There was no toilet paper holder in bathroom. The Family member present stated the resident's room had been without paper towels now for twelve days and that the bathroom had not had a toilet paper holder since resident was moved into that room. During an interview on 12/04/2025 at 8:28 AM, the Director of Nursing/Infection Preventionist stated all body washes and lotions should be labeled, and have caps present on them to prevent cross contamination. Additionally, they stated personal care items should not be stored in the bathroom for infection control reasons. During an interview on 12/04/2025 at 8:28 AM, the Director of Nursing/Infection Preventionist stated Resident room [ROOM NUMBER]'s bathroom had an odor. They stated the bathroom needed to be disinfected, deep cleaned for a homelike environment. During an interview on 12/04/2025 at 8:41 AM, Registered Nurse #5 stated the shower room stall was unsanitary due to the floor having dirt debris, clumps of hair, and wrappers on the floor. They stated the nursing aides should be cleaning the shower stall after resident care and then letting housekeeping know if additionally, cleaning was needed. They stated the shower stall was not homelike and should be cleaned thoroughly for infection control purposes. During an observation and interview on 12/04/2025 at 9:18 AM, Registered Nurse #5 stated the maintenance department places mattress on beds and that if there was an issue with a mattress, they would place a work order into the computer. Registered Nurse #5 stated Resident #67 has never brought any concerns regarding their mattress to them. Registered Nurse #5, removed bottom sheet covering mattress and stated the mattress looked unsanitary due to the outer waterproof cover being ripped, peeling and was stained. Additionally, they stated in the past they have been told the facility did not have replacement mattresses available. During an observation and interview on 12/04/2025 at 9:25 AM, Certified Nurse Aide #10 stated Resident #67's air mattress was ripped, stained and was not sanitary. They stated the Housekeeping/Laundry Supervisor was aware of it and believed an unknown nurse placed an electronic work order about a month ago. They stated the air mattress alarms all the time and that Resident #67 will not sleep with their head at the head of the bed due to the unsanitary condition of the mattress. During an observation and interview on 12/04/2025 at 8:52 AM, the Housekeeping/Laundry Supervisor stated the nursing aides were responsible for cleaning the shower stall and equipment after use. They stated they would expect the housekeeping staff to mop the shower room floors daily but had to find out who cleaned the wall tiles. They stated disinfectant was supplied for sanitizing the equipment in the shower room but that it disappears all the time. There was no disinfectant for sanitizing present in the shower room. Additionally, they stated prices for supplies have gone up and their budget had not changed. They stated they have to supply rooms for a 120 people and the kitchen with paper towels and they only order supplies once a month with the Administrator. They stated supplies, paper towels, were limited and they do not have enough to supply the whole building. They stated they have run out and they must tell the staff, Sorry. During an interview on 12/04/2025 at 10:37 PM, Registered Nurse #5 stated nurses were responsible to change oxygen tubing weekly and they believed the maintenance department was responsible to clean the oxygen concentrators and filter. Registered Nurse #5 stated Resident #5's filter was covered in dust and should be cleaned. During an interview on 12/05/2025 at 7:20 AM, the Director of Nursing/Infection Preventionist stated approximately a week ago a staff member brought Resident #67's mattress to their attention and it was discussed at morning meeting. They stated Resident #67's mattress was supposed to be swapped out with a regular mattress because Resident #67 did not have any wounds; requests for replacement mattress was not placed in the electronic work order system if it is an emergency, they call the Maintenance Director directly. Additionally, they stated there have been no concerns brought to their attention regarding lack of supplies. They stated it was important for resident bathrooms to have paper towels so staff can dry their hands after washing them for infection control purposes. During an interview on 12/05/2025 at 9:45 AM, Maintenance Supervisor, in the presence of the Maintenance Director, stated all work orders were supposed to be (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed in the electric work order system. They stated the Director of Nursing told them last week Resident #67 needed a new mattress, and they told the Director of Nursing that a new one needed to be ordered. They stated they did not have any bariatric mattresses available. Maintenance Supervisor stated they go through the facility and check mattresses once a month. They stated a mattress was not thrown away until after the Maintenance Director approved it. The Maintenance Director stated they do not have any documented evidence of the resident's mattresses being checked/audited monthly. During an interview o 12/08/2025 at 11:16 AM, Licensed Practical Charge Nurse #2 stated they believed maintenance was responsible to clean oxygen concentrator filters and were usure how often that should be done. They stated it would be important to have the oxygen filters cleaned for infection control purposes, additionally they stated a dusty filter may interfere with the functioning of the oxygen. During an interview on 12/08/2025 at 2:24 PM, the Director of Nursing stated there was no scheduled for cleaning oxygen concentrators and filters. They stated any staff member could wipe down the oxygen concentrators with bleach wipes and clean the oxygen filters; they would expect this to be done when needed to remove dust and debris. The Director of Nursing stated it was important to keep the oxygen concentrator filters clean and free from dust for infection control reasons. During an interview on 12/8/25 at 4:54 PM, the Administrator stated all oxygen concentrators received routine service from an outside contracted company. They stated the contracted company came annually to the facility to inspect all equipment and were present in the building monthly to repair any equipment including oxygen concentrators if needed. The Administrator stated they were unsure if there was a routine cleaning schedule for oxygen concentrators and filters and did not know who was responsible to clean them. 10 NYCRR 415.5(h)(1)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the Standard survey completed on 12/09/2025, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, to help prevent the development and transmission of communicable diseases and infections for three (3) (Residents #4, #19, and #41) of three (3) residents reviewed for infection control. Specifically, during a wound care observation, Resident #4's soiled brief and soiled wound dressing were placed directly on the floor without a barrier; staff did not wear personal protective equipment including gowns during wound care, personal care, and transferring of Resident #41, who was on enhanced barrier precautions; a nurse dispensed Resident #19's medications into their bare hands, when the medications fell onto the top of the medication cart, the nurse placed the medications into souffle cup with ungloved hands and was prepared to administer medications to the resident; and during a medication observation, staff's personal beverages were observed on the top of the medication cart. Additionally, there was no conspicuous signage throughout the facility offering COVID-19 vaccinations/boosters per facility protocols. The findings are:The policy titled Enhanced Barrier Precautions, dated 04/01/2024, documented enhanced barrier precautions were used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDRO) to residents. Gloves and gowns were to be applied prior to performing high contact resident care. Examples of high contact resident care activities requiring the use of gown and gloves included dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting, and wound care. Enhanced barrier precautions were indicated for residents with wounds and/or indwelling medical device that placed them at increased risk and would remain in place for the duration of the residents stay or until resolution of the wound or discontinuation of indwelling medical device. Signs were posted on the door or wall outside the resident room indicating the type of precautions and personal protective equipment required.The policy titled Infection Prevention and Control Program, last revised 05/23/2025, documented the infection prevention and control program was a facility wide effort involving all disciplines and individuals and was an integral part of the quality assurance and performance improvement program. The elements of the program consisted of coordination/oversight, policies and procedures, prevention of infection, and identifying, recording and correcting infection control program incidents.The policy titled Administering Oral Medications dated 12/01/2017, documented the desired number of tablets or capsules from a bottle are poured into the bottle cap and transferred to the medication cup. Do not touch the medication with your hands. Place packaged unit dose tablets or capsules medications directly into the medication cup.The policy titled Storage of Medications dated 12/01/2017, documented nursing staff shall maintain medication storage and preparation areas in a clean, safe and sanitary manner.The policy titled COVID-19 Vaccinations of Nursing Home Residents and Personnel revised 09/30/2024, documented there will be conspicuous signage throughout the facility offering COVID-19 vaccinations/boosters.1.Resident #4 had diagnoses that included congestive heart failure, diabetes mellitus, and pressure ulcer of sacral (area above the tail bone) region unspecified stage. The Minimum Data Set (a resident assessment tool) dated 10/31/2025, documented Resident #4 was cognitively intact, required partial/moderate assistance (helper does less than half the effort) for personal hygiene and was dependent (helper does all the effort) on staff for toileting hygiene. Resident #4 had an indwelling catheter (tube inserted into the bladder to drain urine), a colostomy (artificial connection of the bowel to the skin surface), and one (1) Stage 3 (full thickness tissue loss) pressure ulcer.The comprehensive care plan dated 10/27/2025 documented Resident #4 was at risk for infection related sacral pressure ulcer. Interventions included enhanced barrier precautions; skin care as ordered; and administer medications as ordered. The resident had an alteration in elimination related to colostomy and indwelling catheter. The Physician (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound Consultant note dated 11/28/2025 documented Resident #4 had a stage 3 (full thickness tissue loss) left posterior thigh pressure ulcer and a stage 3 pressure ulcer to their coccyx (tailbone) with a moderate to large amount of purulent (pus like fluid yellow or green in color) drainage.During an observation of wound care on 12/04/2025 at 11:16 AM, Licensed Practical Nurse #6 and Certified Nurse Aide #7 performed hand hygiene, donned gown and gloves and turned Resident #4 onto their right side. Certified Nurse Aide #7 unfastened the resident's incontinence brief and two (2) wound dressings were observed on the coccyx and left posterior thigh. The wound dressing to Resident #4's coccyx was observed with moderate amount of yellow drainage that had soaked into Resident #4's incontinence brief. Certified Nure Aide #7 rolled up the incontinence brief under the resident and Licensed Practical Nurse #6 removed both wound dressings, cleansed the wounds and applied the wound treatments as ordered. Certified Nurse Aide #7 then rolled Resident #4 onto their left side pulled out the brief soiled with drainage from their wound and placed the brief directly on the floor without a protective barrier in place for the duration of care.During an interview on 12/04/2025 at 11:29 PM, Licensed Practical Nurse #6 stated Resident #4 was on enhanced barrier precautions because they had pressure ulcers, a foley catheter and colostomy. Licensed Practical Nurse #6 stated Resident #4's brief was soiled with wound drainage and was wet from sweat. They stated during care they observed Certified Nurse Aide #7 remove the soiled brief and place it on the floor without a barrier. Licensed Practical Nurse #6 stated for infection control purposes soiled linen or briefs should never be placed on the floor, there should have been a barrier in place to prevent germs from spreading.During an interview on 12/04/2025 at 11:41AM, Certified Nurse Aide #7 stated while providing care to Resident #4 they had removed their old brief and placed it on the floor. They stated Resident's brief was soiled with light yellow drainage from sweat. Certified Nurse Aide #7 stated they should have placed a barrier down either a sheet, blanket, or used a garbage bag for infection control reasons. They stated it was important to keep the resident's room clean, and germs could spread when soiled items were placed on the floor.During an interview on 12/05/2025 at 3:08 PM, the Director of Nursing/Infection Preventionist stated they expected staff to follow appropriate infection control practices. They stated soiled linen, and briefs should never be placed on the floor, it was an infection control issue and would have expected staff to ensure a barrier was used for all soiled linen and briefs.2. Resident #41 had diagnoses including contracture (permanent tightening and shortening of muscles causing joint stiffness) of muscle, left forearm, major depressive disorder, and paraplegia (paralysis of lower half of body). The Minimum Data Set, dated [DATE], documented Resident #41 was cognitively intact, required partial/moderate assistance (helper does less than half the effort) for rolling left and right and was dependent (helper does all the effort) on staff for toileting hygiene, showering/bathing, and transferring.The comprehensive care plan, dated 12/10/2023, documented Resident #41 was at risk for infection related to comorbidity infection with interventions to monitor for signs/symptoms of infection and maintain enhanced barrier precautions (initiated on 07/12/2024).The Physician Wound Consultant note dated 11/21/2025 documented Resident #41 had a 3.5 centimeter (cm) by 5.5 centimeter by 0.1 centimeter skin tear to their left posterior thigh that had declined in status since the last assessment; was a full thickness wound with fat layer exposed, had a moderate amount of exudate (drainage), and the peri-wound (surrounding skin) was macerated (moist). An alginate dressing (highly absorbent dressing that transforms into a gel) covered with a superabsorbent bordered dressing was ordered.During an observation on 12/03/2025 at 11:23 AM, Resident #41 was being wheeled down the hall towards their room on a shower bed from the shower room by Certified Nurse Aide #18 and Certified Nurse Aide #2. Resident #41 was attached to the Hoyer lift by the Certified Nurse Aides and lifted off the shower bed and wheeled into their room and placed on the bed. Neither certified nurse aide had on a precaution gown during the observation or transfer.During an observation on 12/03/2025 at 11:39 AM, Licensed Practical Nurse #12 and Registered Nurse #3 Unit Manager gathered wound care supplies on the cart outside of the Resident #41's room then entered the room wearing only gloves. Enhanced Barrier Precaution signage was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	posted on the door frame of Resident #41's room. Resident #41 was turned onto their left side by Registered Nurse #3 Unit Manager, Licensed Practical Nurse #12 removed the old dressing from Resident #41s left posterior thigh and placed it in the garbage can next to the bedside. The dressing fell out of the full garbage can and landed on the floor, making a plop noise when hitting floor. Licensed Practical Nurse #12 stated there was dark brown/tan drainage observed on the old dressing and Resident #41 had just received a shower, so they dressing was saturated from the shower. Licensed Practical Nurse #12 removed their gloves, applied new gloves, cleansed wound with normal saline, applied alginate, then covered with superabsorbent dressing, rolled resident #41 over, and secured their brief, cleaned up soiled items, secured resident, then exited the room.During an observation and interview on 12/03/2025 at 11:47 AM, Registered Nurse #3 Unit Manager and Licensed Practical Nurse #12 reviewed the signage outside of Resident #41's door and both stated they forgot to wear their precaution gowns during wound care. Registered Nurse #3 Unit Manager stated Resident #41 was on enhanced barrier precautions so they should have worn their personal protective equipment gown while completing the wound care and it was important to not spread any germs between residents.During an observation on 12/03/2025 at 2:17 PM, Certified Nurse Aide #18 and Certified Nurse Aide #1 were in Resident #41's room, transferring them from their bed to their wheelchair with the Hoyer lift. Neither Certified Nurse Aide had a personal protective gown on.During an interview on 12/03/2025 at 2:19 PM, Certified Nurse Aide #18 stated they had just changed Resident #41 and transferred them to their wheelchair. Certified Nurse Aide #18 stated they should have worn a personal protective gown but forgot to wear one while showering, transferring, and providing incontinent care to Resident #41; it was important to wear personal protective equipment when providing hands on care to Resident #41 because they were on enhanced barrier precautions, and did not want to spread infection or germs around.During an interview on 12/03/2025 at 2:20 PM, Certified Nurse Aide #1 stated they only assisted Certified Nurse Aide #18 with Resident #41's transfer, they did not touch the patient. They stated personal protective equipment should be worn for a resident on enhanced barrier precautions whenever hands on care were performed, because you don't want to spread infection.During an interview on 12/03/2025 at 2:22 PM, Certified Nurse Aide #2 stated they assisted Certified Nurse Aide #18 earlier that day with Resident #41s shower and transfer, did not have on a personal protective gown, and should have. They stated it was important because they did not want to spread anything from resident to resident.During an interview on 12/03/2025 at 2:23 PM, Licensed Practical Nurse #12 stated Certified Nurse Aides #1, #2, and #18 should have all worn a personal protective gown when providing any hands-on care to Resident #41. It was important to prevent the spread of pathogens.During an interview on 12/03/2025 at 2:26 PM, Registered Nurse #3 Unit Manager stated Certified Nurse Aides #1, #2, and #18 should have all worn a personal protective gown when providing any hands-on care to Resident #41. It was important to prevent the spread of bacteria or infection.During an interview on 12/05/2025 at 1:16 PM, Regional Educator and Quality Assurance stated all staff were trained on enhanced barrier precautions in general orientation, annually, and as needed. Staff were trained to wear a gown and gloves whenever providing hands on care was performed on a resident, staff should have worn a gown when transferring, showering, providing incontinent care and wound care to Resident #41 or any resident on enhanced barrier precautions. Regional Educator and Quality Assurance stated there was a risk for contamination and infections if personal protective equipment was not worn.During an interview on 12/05/2025 at 3:08 PM, Director of Nursing/Infection Preventionist stated they expected all staff caring for resident on enhanced barrier precautions to wear gloves and a gown, tied firmly around the waist, during wound, incontinent, or any hands-on care provided to a resident on enhanced barrier precautions. Staff should have worn gowns when providing care to Resident #41. It was an infection control issue. They stated there should always be a barrier placed for soiled linens/dressings; things should never be placed on the floor; it was an infection control issue.3. During an observation and interview on 12/03/2025 at 9:53 AM, [NAME] unit, the [NAME] Drive medication cart had a personal (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pink insulated beverage container and a personal disposable cup with an open lid present on top of the medication cart during medication administration. During medication observation of medications to Resident #19, Licensed Practical Nurse #7 dispensed medication from containers directly into the palm of their hand prior to placing them into a medication cup. During transfer of medication from the palm of their hand into the plastic med cup, medication fell onto the top of the medication cart, was picked up by Licensed Practical Nurse #7 ungloved fingers and placed into the medication cup. Licensed Practical Nurse #7 was prepared to administer the medications to Resident #19 when the surveyor stopped them. Licensed Practical Nurse #7 stated they had cleaned the top of the medication cart prior to the start of their medication pass that morning and had sanitized their hands prior to the initiation of Resident #19's medication pass. Licensed Practical Nurse #7 stated they did touch the outside of the medication cart and items within the medication cart prior to dispensing the medications into the palm of their hand. They stated they should not have dispensed the medications into the palm of their hand or utilized the medication that dropped onto to medication cart due to germs and infection control. They stated they should have dispended the medication directly into the medication cup or utilized a glove prior to utilizing their hand to handle the medication. Licensed Practical Nurse #7 stated they were not supposed to have personal beverages on the medication cart due to infection control, but they forgot.During an observation on 12/04/2025 at 9:13 AM, [NAME] Unit, [NAME] Drive medication cart, had a staff member's personal [NAME] Horton cup present on top of the medication cart while Registered Nurse #5 was administering medications.During an interview on 12/04/2025 at 9:18 AM, Registered Nurse #5 stated their personal beverage should not have been present on the medication cart for infection control reasons. They stated they forgot.During an interview on 12/05/2025 at 7:20 AM, the Director of Nursing/Infection Preventionist stated medications should not be handled by a nurse's bare hands due to infection control. They stated any medication that encounters the surface of the medication cart should be discarded and dispensed again as the surface of the medication cart is not considered clean. The Director of Nursing/Infection Preventionist stated there should not be any personal items, including coffee or water bottles on the medication cart for infection control purposes.4. During intermittent observations from 12/01/2025 to 12/05/2025 between 7:00 AM - 3:00 PM, there was no conspicuous signage throughout the facility offering COVID-19 vaccinations/boosters.During an interview on 12/05/2025, Unit Clerk #1 stated they have not observed any signage in the facility related to the COVID vaccinations being available.During an interview on 12/05/2025 at 10:16 AM, Licensed Practical Nurse #11 stated they were not aware of any COVID vaccination signage posted in the facility.During an interview on 12/05/2025 at 8:48 AM, the Director of Nursing/Infection Preventionist stated they did not have any signage posted in the facility regarding COVID vaccinations.During an interview on 12/08/2025 at 2:08 PM, the Director of Nursing/Infection Preventionist stated they were not aware that signage needed to be posted throughout the facility offering COVID-19 vaccinations/boosters. They stated they would be responsible to take care of that, and had they known they would have posted signage. 10 NYCRR 415.19 (a) (1-3)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review conducted during a Standard survey completed on 12/09/2025, the facility did not ensure a resident was assessed by the interdisciplinary team to determine a resident's ability to safely administer their own medications if clinically appropriate for one (1) (Resident #77) of one (1) resident reviewed for medication self-administration. Specifically, Resident #77 was observed with medications in their room, and they self-administered the medications without being evaluated as to whether they could safely do so. The finding is:The policy titled Self-Administration of Medications dated 12/01/2017 documented residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. Staff shall identify and give to the Unit Manager/Nurse Supervisor any medications found at the bedside that are not authorized for self-administration and return to the family or responsible party.1.Resident #77 had diagnoses including fracture (partial or complete break in a bone) of right femur (long thigh bone), atrial fibrillation (irregular heart rate) and anxiety disorder. The Minimum Data Set (resident assessment tool) accepted on 09/19/2025 documented Resident #77 was understood, understands and was cognitively intact.The Careplan Report dated 09/16/2025 documented Resident #77 was independent for decision making ability. The general orders documented Diphenhydramine Hydrochloride (antihistamine) oral tablet 25 milligrams, 2 tablets by mouth at bedtime started 09/03/2025. There was no documented evidence that Resident #77 was assessed for the ability to self-administer any medications.The undated Medications Profile for Resident #77 documented Diphenhydramine Hydrochloride (antihistamine) oral tablet 25 milligrams, 2 tablets by mouth bedtime for sleep management with a start date of 09/03/2025. There were no physician's orders for Resident #77 to self-administer medications or to leave medications at the bedside. Review of Progress Notes Report dated 09/03/2025 to 12/03/2025, there was no documented evidence that Resident #77 was assessed by the interdisciplinary team to determine if they could safely self-administer their medications and keep them at their bedside. There was no documentation that the resident had self-administered any medications or that any medications were removed from their bedside. Review of medical provider notes dated 10/14/2025 to 11/26/2025 revealed no notes that addressed the resident could self-administer their medications or keep them at the bedside. During an observation on 12/02/202 at 9:14 AM, Resident #77's had an opened clear bottle of soft gel capsules labeled max strength sleep aide, diphenhydramine hydrochloride (antihistamine) 50 milligrams, on their tray table visible from the doorway of their room. During an observation and interview on 12/03/2025 at 9:41 AM, Resident #77 was in bed, an opened clear bottle of labeled soft gel capsules, max strength sleep aide, diphenhydramine hydrochloride (antihistamine) 50 milligrams, remained on their tray table visible from the doorway of their room. Resident #77 stated they take the diphenhydramine hydrochloride occasionally to go to sleep. They stated they brought it from home and the facility prescribed it for them. Resident #77 stated the facility lets them take it by themselves and they had taken it last night. Resident #77 stated the staff knew they had the diphenhydramine hydrochloride on their tray table and had not said anything. Resident #77 then placed bottle of diphenhydramine hydrochloride in their nightstand drawer.During an interview on 12/03/2025 at 9:53 AM, Licensed Practical Nurse #7 stated residents cannot self-administer medications unless it was ordered. They stated they were not aware of any residents having medications ordered to be at their bedside. They stated if medications were observed at the bedside, they would check for orders, remove medications if not ordered and notify whoever was in charge. Licensed Practical Nurse #7 stated having medications at a bedside was a safety concern, residents could self-administer the wrong dose, the medication may not react with other medications they are prescribed, and another resident may gain access to them.During an interview on 12/04/2025 at 9:53 AM, Registered Nurse #5 stated Resident #77 did not have an order (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to self-administer medications or keep mediations at their bedside. They stated Resident #77 had an order for Benadryl (antihistamine) 50 milligrams every night that has been ordered since 09/03/2025 that is administered by nursing staff. They stated they were not aware Resident #77 had medication at their bedside. They stated it was important to know what medications a resident is taking to monitor for any drug-to-drug interactions. They stated if they observed any medications at a resident bedside, they would confiscate them to avoid safety concerns; and inform the nurse manager and provider.During an interview on 12/04/2025 at 12:07 PM, Resident #77 stated their bottle of sleep aid was removed from their room by an unknown nurse that morning. Resident #77 stated they took a gelcap, diphenhydramine hydrochloride, from their bottle last night, 12/03/2025, to help them sleep.During an interview on 12/04/2025 at 12:13 PM, Licensed Practical Nurse #2, Charge Nurse, stated residents are not supposed to have medications kept at their bedside or should they be self-administering medications to themselves without an order. They stated it was a safety concern because they would not know when the resident is taking it or if it was contraindicated with any of the other medications being administered to them. Licensed Practical Nurse #2, Charge Nurse stated they were not aware of Resident #77 having medication at their bedside until they were notified by Registered Nurse #5 that day.During an interview on 12/5/2025 at 7:20 AM, the Director of Nursing stated there is a process that must be followed for a resident to self-administer medication. They stated a medical provider would have to determine if a resident was capable and write an order to self-administer and keep medications at bedside. They stated a consent would have to be signed, education would have to be provided to the resident and a lock box provided. The Director of Nursing stated they knew nothing about Resident #77 having medications at their bedside. They stated they would expect nurses to remove any medication found at a resident's bedside, educate the resident, and call the responsible party.10 NYCRR 415.3(f)(1)(vi)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Safire Rehabilitation of Southtown, L L C	300 Dorrance Avenue Buffalo, NY 14220

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a Standard survey completed on 12/09/2025, the facility did not ensure that the resident can make choices about aspects of his or her life that is important to them. Specifically, two (Residents #82 and Resident #7) of four (4) residents reviewed for choices had issues with not receiving a shower per their preference (Resident #82) and the facility did not honor the resident's preference to get out of bed before breakfast (Resident #7). The findings are:The policy titled Care Plans -Comprehensive revised on 02/01/2018, documented an individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents medical, nursing and psychological needs is developed for each resident. Each resident's care plan is designed to reflect the residents expressed wishes regarding care and treatment and will incorporate the residents personal and cultural preferences in developing goals of care.The policy titled Resident Rights dated 03/01/2017, documented employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility which include the residents right to self-determination and to be informed of and participate in their care planning and treatment.The policy titled Bathing and Showering dated 3/1/2017, documented that the resident will be offered the frequency, days of the week, and location of their showers.1. Resident #82 was admitted to the facility with diagnoses of peripheral vascular disease, cellulitis (infection) of the leg, and chronic pain syndrome. Review of the Minimum Data Set (a resident assessment tool) dated 11/4/2025 documented that the resident was cognitively intact, understood others, understood by others, and it was somewhat important for them to choose between a bed bath or a shower. Resident #82 was dependent on staff for bathing and showering.Review of an undated Certified Nurse Aide Care Profile for Resident #82 documented that the resident was to receive a shower once a week on Wednesdays during the afternoon 3:00 PM to 11:00 PM shift. The care profile documented that the resident was dependent on staff for showering and bathing including washing, rinsing and drying.Review of the comprehensive care plan dated 10/30/2025 documented that the resident bathing and self-care was per Occupational Therapy's recommendations.Review of the Occupational Therapy Evaluation dated 10/30/2025 documented that the resident required a maximal assist of two staff members for bathing due to Resident #82 only able to perform 25% of the bathing task. Further review of the occupational therapy evaluation documented that the resident would need to use a shower chair for bathing.Review of Resident #82's daily shower sheets dated 11/5/2025, 11/12/2025, 11/26/2025, and 12/3/2025 documented that the resident received bed baths or refused bathing.Review of Resident #82's chronological progress notes dated 10/29/2025 to 12/7/2025 revealed no documentation of any resident refusals to take a shower.During an interview on 12/2/2025 at 10:26 AM with Resident #82, they stated that they asked staff when they get a shower, and it was supposed to be on Wednesdays. They stated that they have not received a shower since they have been admitted . They stated that no one asked for their preference to take a shower. They stated that it bothered them as they took a shower every night when they were at home.During an interview on 12/5/2025 at 11:50 AM with Certified Nurse Aide #4, they stated that they never gave a shower to Resident #82. They stated they did not offer a shower to Resident #82 because they thought that the resident could not fit the shower bed, and they didn't think Resident #82 could fit the shower chair. They stated that they did not tell anyone about not getting a shower done.During an interview on 12/5/2025 at 12:10 PM with Certified Nurse Aide #3, they stated they have never given a shower to Resident #82. They stated that Resident #82 was a two assist for a shower so if they don't have enough staff then Resident #82 could not get a shower.During an interview on 12/5/2025 at 1:13 PM with the Physical Therapist, they stated that they were never approached by nursing staff about Resident #82's shower. They stated that if they had known, they could have given showers to (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #82 as part of therapy time.During an interview on 12/8/2025 at 8:38 AM with Licensed Practical Nurse Charge Nurse #2, they stated that they were not aware that Resident #82 was not getting a shower. They stated that they expect staff to report when residents were not getting showers. They stated that they expected staff to document when residents refused a shower and the reason why. They stated that the resident could be lifted into a shower chair and given a shower that way.During an interview on 12/9/2025 at 8:42 AM with the Registered Nurse Regional Educator, they stated that if a resident wanted a shower or their preference was a shower, staff should give the resident a shower as long as the resident was safe. 2.Resident #7 had diagnoses that included congestive heart failure, diabetes mellitus, and chronic obstructive pulmonary disease (progressive lung disease). The Minimum Data Set, dated [DATE] documented Resident #7 was understood, understands and was cognitively intact. Resident #7 had upper extremity functional limitation to one side and required supervision or touching assistance (helper provides verbal cues and/or touching and or contact guard assistance) with transfers. There were no behavioral symptoms or refusals of care documented.The comprehensive care plan identified as current by the Director of Nursing documented Resident #7's preferences were initiated on the care plan on 09/16/2020 and their preferred time to rise varied. There were no revisions made to Resident #7's preferred rise time.The undated care profile (guide used by staff to provide care) identified as current by the Director of Nursing, documented Resident #7's preferred time to rise was on night shift (11:00PM - 7:00AM) by 7:00 AM.Review of the Resident Care Profile (V.3) Form created on 10/08/2025 by the Director of Nursing, documented Resident #7's preferred rise time was on the night shift by 7:00AM.Review of nursing progress notes from 11/05/2025 through 12/05/2025 revealed there was no documented evidence Resident #7 refused to get out of bed at their preferred rise time.During an observation and interview on 12/01/2025 at 1:26 PM, Resident #7 was observed in their room sitting up in wheelchair. They stated they were not given the choice on what time they could get out of bed in the morning. Resident #7 stated they preferred to be up early before breakfast and have expressed their preferences to the Unit Manager. They stated when they asked the certified nurse aides to get up before breakfast, they were told either they had to wait until other resident's had been provided care or needed to wait until there was a second certified nurse aide to help. During observation and interview on 12/03/2025 at 8:56 AM, Resident #7 was lying in their bed and stated it was important to them to be out of bed early, they were independent once in their wheelchair and attended several activities and therapy throughout the day.During intermittent observations made on 12/02/2025 at 9:43 AM and 12/04/2025 at 9:06 AM, Resident #7 was observed to be lying in bed.During an interview on 12/04/2025 at 9:10 AM, Certified Nurse Aide #6 stated they were assigned to Resident #7 and were informed from other staff they preferred to get out of bed between 10:00 AM - 11:00 AM. They stated the resident care profile specified what time a resident preferred to go to sleep but was unsure if it specified a preference time to get out of bed. Certified Nurse Aide #6 stated the nurses communicated to them what residents needed to be up for therapy or had early appointments and those resident's received care first. Certified Nurse Aide #6 stated Resident #7 did not request to be up before breakfast.During a telephone interview on 12/04/2025 at 4:56 PM, Certified Nurse Aide #15 stated they worked the night shift (11:00PM - 7:00AM) and were familiar with Resident #7, they stated they were not assigned to Resident #7 and had not provided care to them. Certified Nurse Aide #15 stated the nurse would inform the certified nurse aides which residents were to be up early on their shift and Resident #7 was not an early get up.During a telephone on 12/04/2025 at 5:11PM, Licensed Practical Nurse # 5 stated they worked the night shift (11:00PM- 7:00AM) and there were two (2) residents scheduled to be up early on their shift. They stated the Unit Manager determined what residents were to be up early and Resident #7 was not an early get up. Licensed Practical Nurse #5 stated Resident #7 had requested in the past to be up early but due to staffing they sometimes worked with only one or no certified nurse aides and were unable to get Resident #7 out of bed.During an interview on 12/05/2025 at 2:53 PM, Certified Nurse Aide #16 stated they provided care to Resident #7 today and (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had assisted them out of bed between 9:00 AM - 10:00 AM. They stated Resident #7 had not requested to be out of bed earlier and were unsure if the care profile listed a resident's preferred rise time. Certified Nurse Aide #16 stated they would be verbally informed by other staff members if a resident needed to be up early otherwise, they worked their way down the hall to get every resident up.During an interview on 12/05/2025 at 2:59 PM, Licensed Practical Nurse Manager #1 stated resident preferences were listed on the care plan and care profile, they were reviewed and updated quarterly or when a resident requested a change. They stated if a resident had a preference to be up early it would be documented on their care plan and care profile and expected staff to follow the care plan. Licensed Practical Nurse Manager #1 stated Resident #7 had expressed to them in the past they preferred to be up before breakfast, they were independent in their wheelchair and liked to travel around the facility. They stated the night shift currently assisted two (2) residents out of bed in the morning and Resident #7 was not one of those residents. Licensed Practical Nurse Manager #1 pulled up Resident #7's care profile in the electronic medical record and reviewed their preference for rise time. They stated they were aware Resident #7 was to be out of bed by 7:00 AM but was not being followed due to staffing. Licensed Practical Nurse Manager #1 stated they were responsible to ensure certified nurse aides followed the care plan, it was important to honor resident preferences because this was their home.During an interview on 12/05/2025 at 4:28 PM, the Director of Nursing stated resident preferences were obtained on admission and could be updated anytime the resident requested to make a change. They stated certified nurse aides would know a resident's preferred rise or bedtime by looking at the care profile and would expect them to review the care profile prior to care and honor the resident's preferences because it was their home. During the interview the Director of Nursing reviewed Resident #7's care profile and stated the residents preferred time to rise was on night shift by 7:00 AM. They stated staff should have honored Resident #7's preference and attempted to get them out of bed at their preferred time.10 NYCRR 415.5 (b)(1)(3)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review conducted during a Standard survey completed on 12/09/2025, the facility did not ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming for two (2) (Residents #44 and Resident #5) of two (2) residents reviewed for nail care. Specifically, Resident #44 had long fingernails on their right hand, and Resident #5 had long fingernails with brown debris underneath. The findings are:The policy titled Care of Fingernails dated 06/26/2018 documented the purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care included daily cleaning and regular trimming on resident assigned bath/shower day. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. Only Licensed Nurses will cut diabetic nails. If a resident does not receive a bath/shower or refused on the scheduled bath or shower day, nail care is still to be provided. If the resident refused the procedure, the reasons why and interventions taken were to be documented on the Activities Daily Living record and/or the medical record.1. Resident #44 was admitted to the facility with right hemiplegia (paralysis on the right side of the body), a cerebral infarction (stroke) and aphasia (ability to speak affected). Review of the Minimum Data Set (a resident assessment tool) dated 05/15/2025 documented that the resident was moderately cognitively impaired, was understood by others, understands others, and the resident required some assistance with activities of daily living. Review of the undated certified nurse aide care profile documented that Resident #44 had a shower day on Monday day shifts.Review of the comprehensive care plan dated 7/16/2025 documented that Resident #44 has an impaired self-care function. The care plan did not address nail care.Review of a progress note dated 08/19/2025 at 11:53 AM, documented that Resident #44 had long, thick fingernails and the Assistant Director of Nursing trimmed them. Review of nursing progress notes from July 2025 to December 2025 revealed no documentation the resident refused nail care.During an observation and interview on 12/02/2025 at 9:07 AM, Resident #44 had one-inch-long fingernails on their right hand. The resident stated that they could not cut their own nails due to their stroke. They also stated that the length of the nails bothered them.During an observation on 12/03/2025 at 8:22 AM, Resident #44's right hand was observed to have an 1/2 inch long nail on the right thumb. The right hand is contracted and observed were three fingers with one-inch-long nails. During this observation, the resident put their thumb out and stated, cut this and made a scissor cutting motion with their left hand.During an interview on 12/03/2025 at 10:15 AM with Certified Nurse Aide #2, they stated that Resident #44's nails should not be that long. They stated that the nurses usually trimmed the nails once a week. They stated if a resident refuses, they are supposed to report it to their nurse.During an observation and interview on 12/3/2025 at 10:30 AM, Registered Nurse Supervisor #1 observed Resident #44's nails and stated that the resident's nails should not be that long. They stated that if the resident refuses to get their nails cut, staff should reapproach them. They stated that the nails could dig into Resident #44's skin and cause open areas. During this interview, Registered Nurse Supervisor #1 asked the resident if they wanted to have their nails trimmed and they replied yes.During an interview on 12/09/2025 at 8:39 AM with the Registered Nurse Regional Educator, they stated that if the resident refuses nail care, staff should document it and report it to their nurse. They stated that activities of daily living are part of grooming and staff are taught to complete these tasks.2. Resident #5 had diagnoses that included diabetes mellitus, chronic kidney disease and congestive heart failure. The Minimum Data Set, dated [DATE] documented Resident #5 was understood, understands and had moderate cognitive impairment. The resident required substantial/maximal assist (helper does more than half the effort) for personal hygiene and was dependent (helper does all the effort) on staff for shower/bathing. There were no refusals of care documented.Review of the comprehensive care plan dated 10/24/2025 documented Resident #5 had a diagnosis of diabetes mellitus, and they preferred to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be showered on Wednesday on the day shift (7:00AM -3:00PM). The care plan did not document the resident's nails were to be trimmed and cleaned by a nurse.Review of the undated care profile (a guide used by staff to provide care), identified as current by the Director of Nursing, documented Resident #5's bathing schedule was one time a week on Wednesdays during the day shift (7:00AM - 3:00PM). The activities of daily living assessment on the care profile dated 12/03/2025 documented Resident #5 required moderate assistance of one (1) staff member for shower/bathing and personal hygiene. The care profile did not document Resident #5 was a diabetic and nails were to be trimmed and cleaned by a nurse.Review of the Physician Order Form dated as of 12/05/2025 revealed there was a physician order for licensed nurse to cut fingernails weekly every Wednesday one time a week with a start date of 10/24/2025.The Treatment Administration Record dated 11/01/2025 - 11/30/2025 and 12/01/2025 - 12/31/2025 documented on 11/12/2025 and 12/03/2025 Resident #5's fingernails were not cut and there were no refusals documented. The Daily Shower Review sheet dated 12/03/2025 documented Resident #5 had refused their shower, received a bed bath and nail care was not signed off as being completed. Review of Resident #5's progress notes dated 11/01/2025 through 12/03/2025 revealed there was no documented evidence the resident refused nail care.During intermittent observations on 12/01/2025 at 9:05 AM, 12/03/2025 at 8:53 AM, and 12/04/2025 at 8:52 AM, Resident #5's fingernails were observed to be long beyond the finger pads on both hands, approximately 1/2 - 1 inch long, jagged and had thick dark brown debris present under nails.During an interview and observation on 12/03/2025 at 4:40 PM, Resident #5 was sitting up in bed eating a soft dinner roll using their right hand. Resident #5's fingernails remained long and extended over pads of fingers, dark brown debris noted around nail beds and under nails. Resident #5 stated they would be ok if staff cut and cleaned them. During an interview on 12/04/2025 at 10:25 AM, Certified Nurse Aide #10 stated nail care was to be completed on shower days or whenever nails were too long or dirty. They stated the certified nurse aides were responsible to cut the resident's nails unless a resident had a diagnosis of diabetes, then the nurse would be responsible for the resident's nail care. Certified Nurse Aide #10 stated they had just provided care to Resident #5 and assisted them out of bed. Certified Nurse Aide #10 entered Resident #5's room at 10:29 AM and stated the resident's fingernails were too long and had thick debris built up under the nails. They stated Resident #5's shower day was last evening, and their nails should have been cleaned and trimmed. Certified Nurse Aide #10 stated they did not notice Resident #5's nails when they provided care to them today and were unsure if they had a diagnosis of diabetes.During an observation and interview on 12/04/2025 at 5:26 PM, Certified Nurse Aide #11 stated they were assigned to Resident #5 last evening, they refused their shower and had requested a bed bath. Certified Nurse Aide #11 stated resident's nails were to be cut on shower days by the certified nurse aides unless the resident was diabetic then it was the nurse's responsibility. Certified Nurse Aide #11 observed Resident #5's fingernails and stated their nails were long and had dirt underneath their nails. They stated while providing a bed bath to Resident #5 last evening they had fecal matter on their hands, they were focused on cleaning their hands and did not look underneath their nails or notice the length. They stated Resident #5's nails should have been cut and cleaned. Certified Nurse Aide #11 stated nail care was important for cleanliness and dignity. During an interview on 12/04/2025 at 10:37 AM, Registered Nurse #5 stated nurses were responsible to cut resident's nails if they had a diagnosis of diabetes. They stated nail care should be done on shower days and documented on the Treatment Administration Record. Registered Nurse #5 observed Resident #5's nails and stated they were long with thick dirty debris underneath the nail. They stated the length of Resident #5's nails appeared to be more than one week growth. Registered Nurse #5 stated Resident #5 was a diabetic and their nails should have been cut yesterday by the nurse after their shower. They stated nail care was important for personal hygiene and safety.During an interview on 12/04/2025 at 10:48 AM, the Director of Nursing stated they expected resident's nails to be cut and cleaned on their shower day and anytime it was needed. They stated the nurses were responsible for nail care for residents with a diagnosis of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diabetes, the certified nurse aides completed nail care for all other residents. The Director of Nursing observed Resident #5's nails and stated they were long with yellow discoloration and had thick brown debris under the nail that may be skin build up. They stated the length of the Resident #5's nails was possibly more than one week's growth. They stated they would have expected the nurse to have soaked Resident #5's nails to remove all the debris and trimmed their nails. The Director of Nursing stated nurses were to sign out on the Treatment Administration Record when nail care was completed and would expect refusals to be documented. They stated an X on the Treatment Administration Record indicated care was not provided. The Director of Nursing stated they would have expected staff to notice when nail care was needed, it was important for infection control.10 NYCRR 415.12 (a) (3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review conducted during a Complaint investigation (Complaint #2609916) during the Recertification Survey completed on 12/09/2025, the facility did not ensure that all residents receive treatment and care in accordance with professional standards of practice for two (2) (Resident #8 and #145) of five (5) residents reviewed. Specifically, there was a delay in obtaining an order for pain management and an x-ray for a resident who sustained a fall and subsequently had a clavicle fracture (break in the S-shaped bone connecting your shoulder blade (scapula) to your breastbone (sternum) (#145). Additionally, there was no assessment or treatment initiated to a skin tear on Resident #8's right forearm. The findings are:The policy and procedure titled Accidents and Incidents- Investigation and Reporting revised 12/10/2021, documented all incidents involving a resident shall be documented on at the time of the incident. Whenever an incident/accident occurs, the involved staff will immediately notify the Unit Manager and Nurse Supervisor.1. Resident #145 had diagnoses including Alzheimer's disease (a progressive brain disorder, characterized by memory loss, impaired thinking, and behavioral changes, stemming from abnormal protein buildup (plaques and tangles) that kills brain cells over time), repeated falls and type two (2) diabetes mellitus (a chronic condition where the body doesn't use insulin properly). The Minimum Data Set (a resident assessment tool) dated 12/23/2024 documented that Resident #145 had moderate cognitive impairment, was sometimes understood, and usually understands others. The resident had no rejection of care and required supervision/touch assist with transfers. The Careplan Report established 12/23/2024 documented Resident #145 was at risk for pain. Interventions included to administer pain meds as ordered, use adjunctive pain-relieving measures as indicated-repositioning, reassurance, emotional support and distraction when appropriate, and use verbal or non-verbal pain scale before and after interventions. The goal was that the resident's pain would be recognized, assessed and treated appropriately through next review.The undated Care Profile (a guide used by staff to provide care) documented Safety Precautions: Fall; skid socks at all times, as tolerated; encourage shoes/sneakers out of bed; encourage proper footwear out of bed; and bed in lowest position. A Full QA (quality assurance) Report completed by the Director of Nursing dated 12/23/2024 at 4:15 PM documented Resident #145 had an unwitnessed fall in their bedroom and was found lying on their left side on the floor which resulted in bruising to the back of their left scapula (shoulder blade). Resident #145 provided a statement tht was documented as I was trying to get into bed and slipped. The report documented ice was applied and Acetaminophen was given per resident request as an immediate intervention/first aide. Nurse Practitioner was notified on 12/23/2024 at 4:33 PM and no new orders were received. The report conclusion documented that an x-ray was completed, and Resident #145 sustained a left non-displaced clavicle fracture. There was no identified abuse or mistreatment. The Progress Notes completed by Registered Nurse #2 Supervisor dated 12/25/2024 documented at 8:43 AM, Resident #145 complained of pain on a scale of (one)1-(ten)10 as being a 10 (ten). They documented that the bruising was in different stages of healed and when pressing in, on/around shoulder joint Resident #145 experienced pain. At 9:02 PM on 12/25/2024 Registered Nurse #2 Supervisor documented Resident #145 complained of pain in left shoulder, and they were requesting an x-ray. Registered Nurse #2 Supervisor documented they had informed Resident #145 that it was a holiday, and x-rays were not being done. There was no documented evidence the medical provider was notified of the resident's pain level and had requested an x-ray.The Daily Unit Report (nursing twenty-four report sheets) dated 12/25/2024 Registered Nurse #2 Supervisor on the evening shift documented that Resident #145 was status post (after) day two (2) from fall and wanted an x-ray of their left shoulder. Further review revealed on 12/26/2025 the day shift nurse documented the resident received Tylenol with positive effect.The Monthly MAR (Medication Administration Record)- TAR (Treatment Administration Record) documented an order dated 12/26/2024 for Acetaminophen (Tylenol) 325 milligrams two (2) tablets every six (6) hours as (continued on next page)

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Safire Rehabilitation of Southtown, L L C	300 Dorrance Avenue Buffalo, NY 14220

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed for pain management. Resident #145 received Acetaminophen (Tylenol) 325 milligrams, 2 tablets (650 milligrams) on 12/26/2024 at 11:35 AM, 12/27/2024 at 5:29 AM, 12/28/2024 at 4:54 PM and 12/29/2024 at 5:37 AM. Additionally, prior to the order dated 12/26/2025 there were no physician orders for pain management.The Provider note signed by the Physician Assistant #1 dated 12/27/2024, documented Resident #145 was being seen per staff reports of a left shoulder contusion (bruise) after a recent fall. The Physician Assistant documented left shoulder contusion was diffuse but more posteriorly (toward the back of the body), range of motion was restricted with reported pain. New order for left sided shoulder x-rays for further evaluation and pain management as needed. The Final Radiology Report dated 12/27/2024 documented recent fracture of the distal (outer) clavicle.During a telephone interview on 12/08/2025 at 12:55 PM, Registered Nurse #2 Supervisor stated residents have the right to request an x-ray no matter what, even if they do not see anything wrong. They stated if a resident requested an x-ray, they would notify a medical provider because it was important to honor the resident's rights. Registered Nurse #2 Supervisor stated they kind of remembered writing progress note on Resident #145 on 12/25/2024 regarding their request for an x-ray. But they did not know if an x-ray had been completed prior to that and could not recall if they looked to see if Resident #145 already had an x-ray. Registered Nurse #2 Supervisor stated they could not recall if they notified a medical provider of Resident #145's request for an x-ray or about their pain level. Registered Nurse #2 Supervisor stated they believed but could not recall if they spoke with the Director of Nursing or a medical provider and they told them to wait on getting an x-ray. They stated they should have documented who they spoke with, and the recommendations given so it showed they reported it to somebody. During an interview on 12/08/2025 at 2:08 PM, the Director of Nursing stated x-rays could be completed at the facility. They stated on a holiday the facility was at the mercy of the x-ray provider, because the x-ray company was limited and completed x-rays on a case-to-case basis. They stated if Resident #145 requested an x-ray on 12/25/2024 it should have been honored, and a provider should have been notified. If an x-ray could not have been done on a holiday, then the provider should have been updated, and if needed the resident could have been sent to the hospital for evaluation. The Director of Nursing stated they did not know why an x-ray of Resident #145's left shoulder wasn't ordered until 12/27/2024. The Director of Nursing also stated they did not recall receiving a message or being notified of Resident #145's request for an x-ray. The Director of Nursing stated they expected residents to be medicated for pain as ordered and for a provider to be contacted if pain was not controlled. During a telephone interview on 12/09/2025 at 8:08 AM, the Physician Assistant #1 stated they expected staff to give what was available for pain then contact provider if pain was not relieved. They stated that it was not appropriate to tell a resident who was having pain and requesting x-ray that an x-ray could not be done on a holiday. They stated they expected staff to call a medical provider to let them know and they would send the resident out to hospital for an x-ray if it couldn't be done in a timely manner. They stated that they were not aware the resident was in that much pain as it was not relayed to them.During a telephone interview on 12/09/2025 at 8:16 AM, the Customer Service Representative for the portable x-ray service company stated they were open on Christmas and Christmas eve. They stated all the facility staff would have had to do was call, and they would have sent someone out as soon as they could.During an interview on 12/09/2025 at 8:44 AM, the Registered Nurse Regional Educator stated if staff could not get an x-ray completed on a resident in house, then the staff should send the resident out. They stated they would expect staff to update the provider and the Director of Nursing.During a follow up interview on 12/09/2025 at 8:51 AM, Registered Nurse #2 Nursing Supervisor stated if a resident complained of pain ten out of ten, they would tell the cart nurse so the cart nurse could administer pain medication, the cart nurse may not always click it off. Registered Nurse #2 Nursing Supervisor stated they could not remember if they gave Resident #145 any pain medication on 12/25/2024 or if they told Licensed Practical Nurse #3 to administer pain medication to Resident #145. They stated it would be documented in Resident #145's medical administration record if it was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered.During a telephone interview on12/09/2025 at 9:20 AM, Licensed Practical Nurse #4, stated after the fall on 12/23/2025 Resident #145 had pain to their left shoulder and that was what prompted the facility to get the x-ray. They stated that they did not recall what the resident's pain level was, but that the resident was complaining of pain, and they recall giving the resident something for pain. They stated they remember Resident #145 only having Tylenol ordered for pain. They stated Resident #145 had bruising to their left shoulder area. They stated that it should be documented in the medication administration record if pain meds were given, and/or in the progress notes. During an interview on 12/09/2025 at 10:15 AM, the Administrator stated they had no knowledge of the situation with Resident #145 and was not aware of the delay in treatment, if there was one. During an interview on 12/08/2025 at 11:14 AM with the Medical Director, they stated that if the resident requested to be sent to the hospital, the resident should be sent to the hospital. They stated that it is the resident's right to go to the hospital. They stated that they expect staff to call them if the resident's pain was not managed and to get new orders for stronger pain medication. 2. Resident #8 had diagnoses that included right femur fracture (break in the long leg bone), dementia and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 09/08/2025, documented Resident #8 was severely cognitively impaired, rarely/never understood and rarely/never understands others. The Minimum Data Set documented, Resident #8 was dependent for transfer and bed mobility, and a maximal assist for toileting, dressing, bathing. The Careplan Report dated 10/24/2025 documented Resident #8 was at risk for impaired skin integrity. Interventions included to apply skin barrier ointment after each episode of incontinence as needed, dietary assessment, pressure relief cushion and mattress, skin care as order. The undated Care Profile (a guide used by staff to provide care) documented Resident #8 was at high risk for skin breakdown and staff were to check skin with routine care each shift. The Daily Shower Review [NAME] Unit dated Tuesday 11/25/2025 documented Resident #8's room number and documented shower given by Certified Nurse Aide #12. Registered Nurse #5's nursing initials were documented on the daily shower sheet indicating a skin check was completed. The Daily Order Report between 8/18/2025 and 11/30/2025 revealed there was no documented evidence a treatment order was initiated to Resident #8's right forearm skin tear. During an observation and interview on 12/02/2025 at 8:49 AM, Resident #8 was in bed and had a skin tear to their right posterior (back) forearm, approximately six (6) centimeters by one (1) centimeter. The wound bed was pale yellow and moist in appearance. There was no drainage noted. Resident #8 stated they did not know what happened but that it was healing. During an observation and interview on 12/04/2025 at 8:02 AM, Resident #8 was in bed with skin tear was still visible to their right forearm that was dry and presented as healing with scab formation. The assigned Certified Nurse Aide #12 stated Resident #8 had a skin tear to their right arm. They stated Resident #8 obtained the skin tear last week on their shower day during a transfer. Certified Nurse Aide #12 stated they reported the skin tear to a nurse and believed it was Registered Nurse #5. They stated it was important to report any resident injuries to a nurse so an accident/incident report could be completed and a proper treatment completed. Review of Progress Notes dated 11/04/2025 through 12/02/2025 revealed there was no documented evidence of an assessment or a treatment to skin tear of Resident #8's right forearm. The Physician's Order Form as of 12/04/2025 documented treatment order to right forearm skin tear: cleanse with 0.9 percent normal saline, pat dry, apply xeroform gauze to the wound bed, dry clean dressing and kerlix wrap daily and as needed. During an interview on 12/04/2025 at 8:14 AM, upon Registered Nurse #5 observing the skin tear present to Resident #8's right forearm they stated they were not aware of this skin tear and should have been informed. Registered Nurse #5 stated an assessment of the skin tear should have been completed, a treatment ordered, area monitored for infection and family notified. They stated a skin check is to be completed weekly on the resident's shower day by a nurse and documented. They stated they did not know why an accident/incident report was not completed but an accident/incident report should have been completed if it was a new injury. During an interview on 12/04/2025 at 8:28 AM, the Director of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing, covering as Unit Manager on [NAME] Unit, stated there was no required nursing documentation with weekly skin checks, unless there was a concern. They stated skin tears should be reported to the nurse, who would then notify them. They stated a measurement should be taken of skin tears, a house treatment implemented, and the provider and responsible party notified. The Director of Nursing stated an accident/incident report should be completed for tracking and investigation reasons. They stated they were not aware of the skin tear to Resident #8's right forearm and there was no assessment, treatment or accident and incident report completed.10 NYCRR 415.12 (a)(2)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review conducted during a Standard survey completed on 12/09/2025, the facility did not ensure residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new ulcers from developing for one (1) (Resident #4) of four (4) residents reviewed. Specifically, the Physician Wound Consultant recommendation dated 10/31/2025 for an air mattress (a mattress that provides air flow to relieve pressure) was not implemented, and Resident #4 developed a new pressure ulcer. The finding is:The facility policy and procedure titled Pressure Ulcers -Risk Assessment and Maintenance of Skin Integrity dated 02/01/ 2018 documented the facility would identify residents at risk for skin breakdown to implement interventions to maintain skin integrity and ensure that residents with pressure ulcers were appropriately assessed and treated. Interventions for reduction of pressure included positioning/protective devices as indicated and all pressure relieving devices will be immediately implemented as per facility policy. Resident #4 had diagnoses that included congested heart failure, diabetes mellitus, and pressure ulcer of sacral (area above the tail bone) region unspecified stage. The Minimum Data Set (a resident assessment tool) dated 10/31/2025, documented Resident #4 was understood, understands, and was cognitively intact. The Minimum Data Set documented Resident #4 required partial/moderate assistance (helper does less than half the effort) for bed mobility and transfers. Resident #4 was at risk of developing pressure ulcers, and had one (1) Stage 3 (full thickness tissue loss) pressure ulcer present on admission. The Comprehensive Care Plan dated 10/28/2025 documented impaired skin integrity related to decreased mobility/strength, diabetes, and Stage 3 pressure ulcer to coccyx (tail bone). The planned interventions included: encourage resident to reposition self every two (2) hours and as needed, pressure relief chair cushion/mattress, skin care as ordered, and weekly skin checks by nurse. The comprehensive care plan was revised on 11/27/2025 to include a Stage 3 pressure ulcer to the left posterior (back) thigh and did not reflect the use of an air mattress until 12/05/2025. The care plan documented the resident had a history of non-compliance and refusing wound care. The undated Care Profile (guide used by staff to provide care) documented Resident #4 was at high risk for skin breakdown. Interventions include routine skin checks, preventative skin care, and turn and position every two (2) - three (3) hours. The Care Profile was not revised to reflect the use of an air mattress. Review of the initial wound and assessment plan dated 10/31/2025 documented by the Physician Wound Consultant revealed Resident #4 had a Stage 3 pressure ulcer on their coccyx. Wound measurements were 4.5 centimeters (length) x 1.3 centimeters (width) x 0.3 centimeters (depth). Preventative wound recommendations included an air mattress and pressure reduction cushion. Review of the wound and assessment plan dated 11/28/2025 documented Resident #4 pressure ulcer to the coccyx had declined and they had developed a new Stage 3 pressure ulcer to the left posterior thigh. The wound onset date was documented as 11/27/2025 and the wound measurements were 0.8 centimeters (length) x 4 centimeters (width) x 0.2 centimeters (depth). The 12/05/2025 wound and assessment plan note documented the pressure ulcer to the left posterior thigh was healing and the pressure ulcer to the coccyx had declined with wound measurements documented as 6 centimeters (length) x 1.3 centimeters (width) x 0.2 centimeters (depth). Review of the nursing progress note dated 11/06/2025 written by the Director of Nursing, documented Resident #4 was seen by the wound physician on 10/31/2025 and a treatment order for Santyl ointment to be applied every day was initiated. There was no documentation in the progress note regarding the recommendations made for an air mattress. Review of all interdisciplinary progress notes from 10/31/2025 - 12/04/2025 revealed no documented evidence that an air mattress had been implemented to Resident #4, and there was no resident refusals documented. Review of the physician progress notes from 11/03/2025 - 12/01/2025 completed by Medical Doctor #1 documented Resident #4 was high risk for skin issues, had a sacral pressure ulcer, pressure relief mattress, and wound care was to continue. There was no (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation in the progress notes that addressed the recommendations made by the Physician Wound Consultant. During an observation and interview on 12/01/2025 at 08:31AM, Resident #4 was observed in bed with a regular standard mattress in place. Resident #4 stated they had reported to the nurse a few days ago they needed a new mattress because it dipped down in the middle, and they would get stuck. Resident #4 stated it was difficult for them to turn and sit up. During intermittent observations made on 12/02/2025 at 09:11AM, 12/03/2025 at 08:25AM, and 12/03/2025 at 03:36 PM, Resident #4 was observed in bed and there was no air mattress present on bed. During an observation on 12/04/2025 at 11:16 AM, Licensed Practical Nurse #6 provided pressure ulcer care to Resident #4's pressure ulcers, they removed the soiled dressings dated 12/03/2025 from both wounds located on the coccyx and the left upper posterior thigh, both areas remained open with a moderate amount of yellow drainage observed from wounds. Licensed Practical Nurse #6 cleansed both wounds with acetic acid solution (wound cleansing solution used to kill bacteria) and treatments were applied as ordered. There was no air mattress present on the bed during the wound care observation. During an interview on 12/04/2025 at 11:29AM, Licensed Practical Nurse #6 stated Resident #4 had two pressure ulcers, was seen by the wound doctor weekly, and often refused to turn and position and to get out of bed. They stated Resident #4 did not have an air mattress and they were unaware how the facility determined which residents were issued air mattresses. During an interview on 12/05/2025 at 10:53 AM, the Physician Wound Consultant stated they completed wound rounds at the facility weekly with the Unit Managers, new recommendations were documented in their notes, and they would print a copy for the facility on the day of the visit. They stated they would expect their recommendations to be followed unless the facility provider did not approve them. The Physician Wound Consultant stated they recommended an air mattress for Resident #4 on 10/31/25 and could not recall if they had seen an air mattress on their bed. They stated air mattresses were recommended for any Stage 3 or Stage 4 pressure ulcers to keep sustained pressure off the wound. The Physician Wound Consultant stated Resident #4 had a Stage 3 pressure ulcer to their coccyx that was present on admission and had developed a new in-house Stage 3 pressure to the left posterior thigh on 11/27/2025. They stated there was no documentation that Resident #4 had refused an air mattress and was unaware the air mattress was not placed. The Physician Wound Consultant stated Resident #4 was quite mobile and was able to turn and position themselves, the air mattress would have been beneficial to relieve pressure but may not have prevented the new wound from occurring. During an interview on 12/05/2025 at 1:16 PM, the Director of Nursing stated they were unaware of the Physician Wound Consultant's recommendation that was made on 10/31/2025 for Resident #4 to have an air mattress. They stated the recommendation was overlooked and should have been implemented. The Director of Nursing stated that the Unit Manager or Charge Nurse were responsible to review the recommendations, have them approved by the provider, and implement the new orders. The Director of Nursing reviewed the wound consult dated 10/31/2025 in the electronic medical record and verified Licensed Practical Nurse #2 Charge Nurse initialed and dated the wound consult on 11/04/2025 and Medical Doctor #1 signed the consult. They stated when Medical Doctor #1 signed the recommendation that indicated they had agreed for the air mattress to be placed on Resident #4's bed. The Director of Nursing stated air mattresses promoted wound healing. During an interview on 12/08/2025 at 11:16 AM, Licensed Practical Nurse #2 Charge Nurse stated when they received recommendations from the Physician Wound Consultant, they would confirm the recommendations with the facility provider and then enter the new orders into the electronic medical record. They stated when an air mattress was recommended, they would contact the maintenance department by phone to request them. Licensed Practical Nurse #2 Charge Nurse stated they had initialed the wound consult for Resident #4 but could not recall why the air mattress was not placed. They stated at times they would be told by the maintenance department that air mattresses were on backorder but was unsure if that was the reason for Resident #4 recommendations not being followed. During a telephone interview on 12/09/2025 at 9:51AM, the Medical Director stated they typically agreed with (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Physician Wound Consultants recommendations. They stated if there was a recommendation for an air mattress, they would expect the facility to follow that recommendation and order an air mattress. The Medical Director stated air mattresses were beneficial to prevent new pressure ulcers, it was a protective device especially when residents laid in bed for long periods of time, would be helpful to prevent skin breakdown. 10 NYCRR 415.12 (c) (2)