STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335669	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Degraff Memorial Hospital-Skilled Nursing Facility	445 Tremont Street North Tonawanda, NY 14120

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint #2678647), the facility did not ensure that all alleged abuse violations were reported immediately but not later than two (2) hours after the allegation was made to the Administrator of the facility and to the State Survey Agency for one (1) (Resident #1) of three (3) residents reviewed. Specifically, staff did not report an allegation of physical abuse to the Administrator immediately which resulted in delayed reporting to the New York State Department of Health within the required time frames. The finding is:The policy titled Identification and Reporting of Abuse, Neglect, Exploitation, or Mistreatment of a Skilled Nursing Facility Resident, as per Public Health Law Section 2803-d last revised on 10/22/24 documented any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation, or misappropriation shall immediately report their concerns to the Nursing Home Administrator or designee. The Long-Term Care Administrator will report abuse to the state agency per State and Federal requirements. The Patient Abuse Reporting Law Section 2803-d requires every nursing home employee and all licensed professionals to report to the New York State Department of Health when there is reasonable cause to believe that a resident has been physically abused, mistreated or neglected. Immediately means as soon as possible but not to exceed two hours after the discovery of the incident.The policy titled Incident Escalation dated 1/7/25 documented all staff are responsible for ensuring the safety and welfare of residents through appropriate notification, response, and follow up. Staff are required to inform their supervisor as soon as they have knowledge of an incident. If their supervisor is unavailable, then the employee is expected to follow the chain in command. Every effort should be made to resolve the incident at the lowest level on the chain of command, however, based on the seriousness of the event, i.e. suspicion of abuse, then the notification of the chain of command may be escalated to the director level.Resident #1 had diagnoses which included diabetes, obesity, and mood disorder. The Minimum Data Set (a resident assessment tool) dated 11/23/2025 documented Resident #1 had intact cognition, was understood and understands. The Minimum Data Set further documented Resident #1 was dependent on staff for toileting needs and required supervision for rolling from left to right in bed. Resident #1 had no documented behaviors.The comprehensive care plan revised on 08/26/2025 documented that Resident #1 had physical limitations related to weakness, declined to get out of bed daily, and was a limited assist of one staff member for bed mobility. The comprehensive care plan further documented Resident #1 was alert and oriented to person, place, time, and made their needs known with some mild memory issues.Review of the New York State Department of Health Complaint Tracking System Complaint/Incident Investigation Report revealed the date/time of the alleged incident was 11/24/2025 at 1:00PM. The date/time the Administrator was first made aware of the incident was 11/26/2025 at 8:00AM. It was submitted by the facility to the New York State Department of Health on 11/26/2025 at 9:15AM.The facility investigation dated 11/26/2025 revealed that Nurse Aide Trainee's #1 and #2 reported to Certified Nurse Aide #2 on 11/26/2025 at 7:35AM that on 11/24/2025 at 1:00PM, they witnessed Certified Nurse Aide #1 slap Resident #1 across the face and was verbally abusive during care. There were no other witnesses to the incident. There were no injuries to Resident #1. Certified Nurse Aide #2 then reported the allegation to Registered Nurse #1 Unit Manager. Nurse Aide Trainee's #1 and #2 were scared, did not know the process for reporting and were fearful of losing their jobs.During an observation and interview on 12/08/20255 at 9:20AM Resident #1 was in bed. There were no indications of abuse. Resident #1 denied being abused physically or verbally by Certified Nurse Aide #1 and stated they just weren't nice, not abusive. During an interview on 12/08/2025 at 10:38AM, Nurse Aide Trainee #1 stated Certified Nurse Aide #1 openly expressed dismay about Resident #1 in common areas such as the hallway or nurses' station but had not said those words directly to the resident. They stated during incontinent care on 11/24/2025 at 1:00PM they witnessed Certified Nurse Aide #1 what they described as being physically and verbally abusive. Certified Nurse Aide #1 was not happy about providing care to Resident #1. Certified Nurse Aide #1 was close to the bed. Nurse Aide Trainees #1 and #2 stood by the closet. Certified Nurse Aide #1 told Resident #1 you are F. disgusting, you need to wake up and then they saw and heard Certified Nurse Aide #1 slap the resident on the left side of their face. The Nurse Aide Trainees #1 and #2 then started collecting the linen because they didn't know what to do and they didn't say anything to Certified Nurse Aide #1 or Resident #1. Nurse Aide Trainee #1 stated Resident #1 was not fazed by the slap as Resident #1 was asleep. Resident #1 opened their eyes and then closed their eyes and didn't say anything. During an interview on 12/08/2025 at