STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335742	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Niagara Rehabilitation and Nursing Center	822 Cedar Avenue Niagara Falls, NY 14301

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38878 Based on observation, interview, and record review conducted during an Abbreviated survey completed on 12/30/24 (Complaint # NY00312953) the facility failed to protect a resident from sexual abuse for one (Resident #1) of three residents reviewed. Specifically, Resident #1 received explicit sexual text messages and a nude picture from a facility Housekeeper #1. The finding is: The policy titled Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigation dated 9/2022 documented all reports of resident abuse, neglect, exploration or theft of a resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Review of the State Operations Manual Appendix PP revised 8/8/24 documented allegations of staff to resident sexual abuse, nursing home staff are entrusted with the responsibility to protect and care for the residents of that facility. Nursing home staff are expected to recognize that engaging in a sexual relationship with a resident, even an apparently willingly engaged and consensual relationship, is not consistent with the staff member's role as a caregiver and will be considered an abuse of power. Resident #1 had diagnoses including illegal polysubstance abuse, hypertension (high blood pressure), and right knee infection. The Minimum Data Set (a resident assessment tool) dated 2/14/23 documented Resident #1 was cognitively intact, was understood, and understands others. There were no behaviors documented during the assessment period. Resident #1's comprehensive care plan documented the following: 3/21/23 they were at risk for victimization. They have been exposed to a nude photo and sexually explicit texts via cell phone. 3/25/23 they will occasionally say things that are not true to avoid accepting responsibility for their actions. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/25/23 they have a behavior problem of sharing their cell phone number with employees despite being advised to avoid doing so. Review of the facility Investigation Summary dated 3/19/23 documented Licensed Practical Nurse #1 was called to the resident's room to see something. The resident explained they were getting messages from Housekeeper #1 that were making them uncomfortable. Resident #1 showed Licensed Practical Nurse #1 a sexually explicit text message and a nude photo including Housekeeper #1's face. The Supervisor, Director of Nursing, and the police were notified. A Progress Note dated 3/21/23 at 5:05 PM, documented the Social Worker spoke with the resident to follow up on the recent incident. The resident stated they were not in any distress and stated they did not want to receive any counseling at that time. They would continue to monitor the resident's mood and behavior for any changes. Review of the local police department Incident Report dated 3/19/23 documented an officer reported to the facility and met with Registered Nurse Supervisor #1 and Resident #1. Resident #1 stated Housekeeper #1 had been continuously harassing them. The first incident happened on 3/15/23, Resident #1 stated they felt violated when Housekeeper #1 woke them up by rubbing their leg but did not touch them sexually, it did alarm them to the point Resident #1 was annoyed. The second incident occurred when Resident #1 gave Housekeeper #1 their cell phone number. Resident #1 stated they received several text messages stating that Housekeeper #1 wanted to engage in sexual relations. The resident never told Housekeeper #1 to stop they just ignored the messages. During an interview on 11/18/24 at 12:42 PM, the Director of Quality Assurance stated they were in the process of completing their annual in-house re-education on abuse and neglect with the staff and had finished the staff education after the incident. During a telephone interview on 11/20/24 at 9:41 AM, Housekeeper #1 stated they worked at the facility back in 2023 as a cleaning person which included resident rooms. They left employment because they were terminated for texting a resident at the facility on their personal phone during non-working hours, Housekeeper #1 did not recall the resident's name who they texted, and they did not recall Resident #1. Housekeeper #1 stated they sent the resident a picture of themself, they believed it was of their face, and the facility thought it was inappropriate and part of their policy that's why they were terminated. Housekeeper #1 could not recall the content of the text message. On 11/20/24 at 10:10 AM, an attempt was made to contact Resident #1 via phone and it was unsucessful. During a telephone interview on 11/20/24 at 10:58 AM, Detective #1 from the local police department stated the case reported in 3/2023 involving Resident #1 was not investigated by the department and the case was closed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/17/24 at 12:54 PM, Licensed Practical Nurse #1 stated they no longer worked at the facility but was employed by the facility at the time of the alleged incident. They were a floor nurse at the time, they stated they were called into the resident's room and Resident #1 showed them a picture of Housekeeper #1 exposed from the waist down with an erection and the housekeeper's face was in the picture. There were also explicit sexual text messages, Licensed Practical Nurse #1 could not recall if the resident responded back to the text messages. They brought the resident's phone to the Supervisor. Resident #1 did not seem like they were in distress or upset at the time. They wrote a statement and had no other involvement in the incident. Afterwards staff were re-educated on abuse. Licensed Practical Nurse #1 stated the incident was inappropriate, but did not feel it was abuse. During a telephone interview on 12/17/24 at 2:22 PM, Registered Nurse Supervisor #1 stated Resident #1 was involved in a texting issue with a staff member. The resident was discharged shortly after. They also stated there was abuse education provided to the staff after the incident. They believed the resident was a consenting participant. During a telephone interview on 12/30/24 at 12:32 PM, the Medical Director stated the situation was inappropriate, but they were two consenting adults and would not consider it abuse. Based on the following corrective actions it was determined the facility implemented corrective actions to correct the non-compliance: Upon entrance to the facility on [DATE] at 8:30 AM, the Human Resource Director had terminated the staff member involved. The facility Director of Nursing at the time had re-educated facility staff on abuse and neglect. During the Abbreviated survey completed on 12/30/24 it was verified through staff interviews and record review that the facility re-educated facility staff on abuse and neglect. 10 NYCRR 415.3 (d)(1)(vii)