STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335834	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highpointe on Michigan Health Care Facility	1031 Michigan Ave Buffalo, NY 14203

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 - Some	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** Based on observation, interview, and record review conducted during a survey the facility did not ensure the resident's right to be free from neglect for twenty two (22) (Residents #1, 2, 3, 7, 8 ,9 ,10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25) of twenty two (22) residents reviewed. Specifically, on 08/18/2025, 08/27/2025, 08/28/2025, and 12/04/2025 staff did not provide incontinent rounds and/or care every two (2) to three (3) hours per the residents' plan of care and safety checks.The findings are but not limited to: 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 revised 10/22/2024 documented that resident abuse and neglect, will not be tolerated. Any staff member or volunteer shall not physically, mentally, sexually or emotionally abuse, mistreat or neglect a resident. Neglect is defined as the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy titled Incontinent Care, Long Term Care revised 11/03/2025 documented that certified nurse aides will be responsible for providing incontinent care and/ or toileting their assigned residents every two (2) to four (4) hours and as needed or as specified per the plan of care. Purposeful rounding is not just a check-in; it's an opportunity to ask open-ended questions and to listen deeply to what matters most to each resident so we can hear their wishes. Long Term Care Certified Nurse Aide Shift Tasks is what is expected of you during your shift but are not limited to: Get report from previous shift nurses; Perform safety rounds, check on your residents to make sure everyone is safe and not on the floor; Answer resident call lights and round on all residents at least every one (1) to two (2) hours. Rounding includes checking that all residents are dry and toileted appropriately. 1. Resident #1 had diagnoses that included quadriplegia (paralysis of all four limbs), diabetes mellitus, and neuropathic bladder (bladder with diminished sensation). The Minimum Data Set (a resident assessment tool) dated 06/15/2025 documented Resident #1 had moderate cognitive impairment and was dependent on staff for toileting and was always incontinent of bowel and bladder. The comprehensive care plan revised on 03/24/2025 documented that Resident #1 was incontinent of bowel and bladder. The plan included to toilet every morning, after meals and at the hour of sleep (bedtime). Check for incontinence and provide care every two (2) to three (3) hours and as needed. Resident #1 required extensive assistance of one (1) staff member for peri-hygiene and clothing management. The Kardex Report dated 08/27/2025 documented Resident #1 was on a toileting plan which included toileting every morning, after meals and at bedtime. Resident #1 was to be checked for incontinence and provided care every two (2) to three (3) hours and as needed. Review of the Complaint/Incident Investigation Report received by the Department of Health on 09/28/2025 documented on August 28th, 2025 that a complaint was made to the social worker stating that Resident #1's family member stated that on 08/18/2025, 08/27/2025, and 08/28/2025 they found Resident #1 with urine-soaked bed linens and T-shirt in bed. The spouse additionally reported that on 08/18/2025 Resident #1 was drenched with urine through their brief, chucks pad (paper pad), cloth pad, and the fitted sheet. Review of Nursing Home Investigative Report completed by the Assistant (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Nursing #1 on 10/01/2025/25 at 1:24 PM, documented they verified neglect had occurred for not following Resident #1's plan of care. Certified Nurse Aides #1 and Certified Nurse Aide #2 were terminated. Review of the facility investigation dated 10/01/2025 documented that video footage from 08/18/2025, 08/27/2025, and 08/28/2028 from 11:00 PM to 5:30 AM was reviewed. During the investigation it was found that on 08/18/2025 Certified Nurse Aide #2 did not enter Resident #1's room at all from 11:00 PM to 5:30 AM. On 08/27/2025 and 08/28/2025 Certified Nurse Aide # 1 only entered Resident #1's room once during 11:00 PM and 5:30 AM. During an interview on 02/17/2026 at 2:30 PM, Assistant Director of Nursing #1 stated they viewed the entire video footage from 08/17/2025, 08/27/2025 and 08/28/2025 between the hours of 11:00 PM to 5:30 AM and created a timeline of events. On 8/17/2025 a nurse went in Resident #1's room with medications at 4:22 AM and left the room at 4:26 AM. No other staff checked on Resident #1 during the entire shift. On 08/27/2025, Certified Nurse Aide #2 entered Resident #1's room once at 3:45 AM and exited the room at 3:49 AM and left with no soiled linens. On 8/28/2025 Certified Nurse Aide #2 entered Resident #1's room at 3:37 AM and left out of the room at 3:39 AM empty handed. The Assistant Director of Nursing #1 stated according to the video footage there seemed to be neglect and they reported it. Certified Nurse Aide #1 and Certified Nurse Aide #2 should have completed rounds every two (2) to three (3) hours and checked and provided incontinent care per the care plan. The Assistant Director of Nursing #1 verified that the following Residents #12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, & 25 were also involved based on review of the camera footage. During observation on 02/18/2026 at 9:30 AM Resident #1 was well-groomed with no evidence of incontinence. Resident #1's family member stated that they come in daily at 5:30 AM and provide care. On 08/18/2025, 08/27/2025 and 08/28/2025 at 5:30 AM Resident #1 was soaked with urine, had brown rings on their brief, the incontinent pads, the bed linens, and the mattress were saturated with urine. During an interview at the time of the observation, the family member stated they spoke Certified Nurse Aide #2, and the aide replied that Resident #1 was a heavy wetter and urinated again after changing them. Resident #1 and their family member both stated no one would enjoy lying in a wet bed and further stated it was undignified and neglectful. During a telephone interview on 02/18/2026 at 2:38 PM, Certified Nurse Aide #2 stated they did not remember Resident #1 on their assignment on 08/18/2025. Certified Nurse Aide #2 stated Resident #1 was well taken care of by them. They completed incontinent rounds every two (2) to three (3) hours. Not everyone required incontinent care and don't like to be bothered. During a telephone interview on 02/18/2025 at 2:42 PM, Certified Nurse Aide #1 stated they checked on Resident #1 twice each night on 08/27/2025 and 08/28/2025. They knew they were held up with another resident on 08/27/2025 and could not provide care by 5:30 AM and left Resident #1 wet. They could not recall a reason on 08/28/2025. Certified Nurse Aide #1 stated they should have asked for help from a nurse and stated their actions were negligent. During an interview on 02/19/2026 at 2:40 PM, Licensed Practical Nurse #3 Unit Manager would expect that Certified Nurse Aide #1 and Certified Nurse Aide #2 would get report for the unit and do safety checks within the first hour. They expected residents to be checked every two (2) hours not just for incontinence but for safety. Leaving Resident #1 lying there in bed wet was mistreatment and morally corrupt. During an interview on 02/19/2026 at 3:45 PM, the Director of Nursing stated Certified Nurse Aide #1 and Certified Nurse Aide #2 did not follow Resident #1's care plan. They were expected to do rounds and to check on every resident on their assignment. Not all residents were wet but needed to be checked for safety. Those residents who could not make their needs known should have been physically checked for incontinence. During an interview on 02/19/2026 at 4:15 PM, the Administrator stated Resident #1's family member's complaint was substantiated. Multiple residents were involved. Not providing care per the care plan was neglectful. 2. Resident #2 had diagnoses that included hemiplegia (paralysis on one side of the body), diabetes mellitus, and urinary tract infection. The Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment. Resident #2 was dependent on staff for toileting and was frequently incontinent of bladder and always incontinent of bowel. The (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Highpointe on Michigan Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1031 Michigan Ave Buffalo, NY 14203	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive care plan revised on 02/20/2025 documented that Resident #2 was incontinent of bowel and bladder. The plan included providing incontinent care every three (3) to four (4) hours and as needed. Resident #2 required an extensive assist of two (2) staff members for toileting and clothing management. The Kardex Report dated 12/4/2025 documented Resident #2 was required to have incontinence care provided every three (3) to four (4) hours and as needed. Resident #3 had diagnoses that included cerebral palsy (CP) (neurological disorder that affects movement, posture, and muscle tone), diabetes mellitus, and seizures. The Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment. Resident #3 required substantial/maximal assistance for toileting hygiene. Resident #3 was always incontinent of bowel and bladder. The comprehensive care plan revised 01/16/2026 documented that Resident #3 was incontinent of bowel and bladder and required incontinent care every four (4) hours and as needed. The plan included to offer assistance to the bathroom before and after meals and at bedtime. The Kardex Report dated 12/4/2025 documented Resident #3 documented to offer toileting every three (3) hours and as needed and to keep their skin clean and dry. Review of the Complaint/Incident Investigation Report received by the Department of Health on 12/19/2025 documented the Administrator was made aware that on 12/04/2025 there was reason to believe neglect occurred. Assistant Director of Nursing #1 received a complaint that residents on the Kensington A-pod (resident unit) appeared to be soaked and had not changed during the night shift 12/04/2025 to 12/05/2025. It was noted that Certified Nurse Aide #4 did not change anyone except two (2) of the 15 (fifteen) residents in the timeframe from 11:00 PM until 5:15 AM. The Nursing Investigative Report completed by Assistant Director of Nursing #1 on 12/23/2025 documented the residents did not recall the incident and there were no signs of psychosocial distress. The conclusion verified neglect. Certified Nurse Aide #4 would be terminated. Review of Licensed Practical Nurse #4 signed statement dated 12/05/2025 at 12:00 PM documented they walked onto the Kensington A-pod (resident unit) at 7:05 AM on 12/05/2025 and immediately smelled a foul odor as the certified nurse's aides were bringing to their attention that none of the residents were touched from the 11:00 PM to 7:00 AM shift, and Resident # 2 was covered in feces. Review of Certified Nurse Aide #4 signed statement dated 12/12/2025 at 3:40 PM documented they could not recall the night of 12/04/2025 from 11:00 PM to 7:00 AM. When they first came in, they normally did a walk through on the pod (resident unit) that they were working. During that time, they checked to see who needed to be changed. They started their second set of rounds at 1:30 AM to 2:00 AM and then a final round at 4:00 AM. Certified Nurse Aide #4 documented they did not sit or sleep at the nurse's station. During an interview on 02/19/2025 at 10:28 AM, Assistant Director of Nursing #1 stated they requested video footage from 12/04/2025 to 12/05/2025 on 12/08/2025 from security and received it on 12/18/2025. After reviewing the entire video footage, employee statements, and documenting a timeline there was concern of neglect. Certified Nurse Aide #4 did not provide care to the residents on the A-pod (resident unit) on the Kensington unit on 12/04/2025 to 12/05/2025 on the 11:00 PM to 7:00 AM shift. The Assistant Director of Nursing #1 stated other residents were involved including Resident #'s 7, 8, 9, 10, and 11. During a telephone interview on 02/19/2025 at 10:01 AM, Certified Nurse Aide #5 stated that not checking or changing your residents was neglectful and was our jobs as aides to help them, that's why they were here. Residents with dementia cannot tell us if they need to be changed. That's why it's important to ensure they are dry and comfortable. During a telephone interview on 02/19/2025 at 10:53 AM, Certified Nurse Aide #7 stated they viewed the video footage from 12/04/2025 in its entirety on 12/12/2025 in the presence of the Assistant Director of Nursing #1. They saw Certified Nurse Aide #4 in the secretary's desk when the call lights were going off. Certified Nurse Aide #4 did not provide incontinent care and if they did enter a resident room they would come right back out with no soiled linens. Certified Nurse Aide #7 verified that Certified Nurse Aide #7 did not provide care and was considered neglect. During a telephone interview on 02/19/2025 at 11:37 AM, Certified Nurse Aide #4 stated they had a bad night and was accused of sleeping and not providing care on 12/04/2025. They told me that I did not go into any rooms with linens, and they told (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	me I was asleep at the nurse's station, which was a lie. They told me, I took a break for one hour and thirty minutes, which I'm guilty of but they worked from 3:00 PM to 11:00 PM and did not get to take a break. Certified Nurse Aide #4 then stated some residents were heavy wetter's and it may look like they were not touched even after changing them. Certified Nurse Aide #4 further stated, not conducting rounds was neglectful. During an interview on 02/19/2026 at 3:45 PM, the Director of Nursing stated Certified Nurse Aide #4 left residents wet and not appropriately cared for the residents per the care plan. Certified Nurse Aide #4 was expected to do their job and know their limitations. They should have asked for help if they felt overwhelmed. Failure to follow the care plan was misconduct and was not up to our standards of care at the facility and was neglect. During an interview on 02/19/2025 at 4:15 PM, the Administrator stated they would have expected Certified Nurse Aide #4 to complete every two (2) to three (3) hour rounding. No residents should ever be untouched for eight (8) hours and that was unacceptable. 10 New York Code Rules Regulations 415.4(b)(1)(i)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review conducted during a survey, the facility did not ensure that each resident received adequate supervision and assistive devices to prevent accidents for two (2) (Residents #4 and #5) of three (3) resident reviewed for accidents. Specifically, the facility did not ensure that Resident #4, who was severely cognitively impaired and at risk for elopement, was adequately supervised to prevent them from exiting through a stairwell door and they were found in the stairwell; the facility did not ensure Resident #5 was reassessed for elopement risk or had interventions in place to prevent/address exit seeking behavior when they had improvement in their functional levels and the resident was found on the sidewalk next to the building by staff. The findings are:The policy titled Elopement Long Term Care/ Missing Person, last revised 12/08/2025, documented it was required and desired for the facility to provide a safe environment for all residents. The facility would properly assess residents and plan their care to prevent accidents related to unsafe behavior and/or elopement. All staff were to know which residents were at risk for elopement and what interventions were needed to minimize the risk of an elopement.The policy titled Wander Guard, last revised 10/27/2022, documented the facility recognized the need to provide a safe and secure environment for residents whose wandering may place them at risk for elopement. The wander guard system in place at the facility was a selective alarm system that was installed on exterior doors and stairwells. The system alarmed when residents wearing a bracelet signaling device attempted to pass through a monitored area.1.Resident #4 had diagnoses including hemiplegia and hemiparesis (paralysis and weakness) following cerebral infarction (stroke), and macular degeneration (loss of the central field of vision as a result of deposits of the retina). The Minimum Data Set (a resident assessment tool) dated 09/21/2025 documented Resident #4 was severely cognitively impaired, usually understands, was usually understood by others, and exhibited wandering behavior one (1) to three (3) in the last seven (7) days.Review of Elopement Risk Scale dated 09/18/2025 documented that Resident #4 was self-ambulatory (could move) with or without a device or self-mobile in wheelchair; was cognitively impaired, with poor decision making skills, and/or with pertinent diagnosis; had a recent history of wandering; had wandered off the unit in the past three (3) months; the wandering was non purposeful; instructions for staff were to care plan Resident #4 for elopement or wandering, educate staff and enter interventions on the interim Care Guide, provide picture of the Resident, distribute the updated poster to all nursing units/floors, departments and switchboard operators when applicable, and had a wander guard in place.The comprehensive care plan, dated 07/27/2024, documented Resident #4 was at risk for elopement with an intervention initiated on 10/17/2024 that staff would need to monitor Resident #4's whereabouts at all times; wander guard was in place and their picture was placed throughout the facility. Resident #4 was a high-risk for falls with intervention that they would be in the common area for close monitoring while awake.The Kardex Report (a guide used by staff to provide care) dated 11/17/2025 documented Resident #4 was able to self-propel their wheelchair short distances with supervision; staff were to propel otherwise.Review of Incident Abstract Report dated 12/01/2025 at 5:43 AM, Security Officer #1 documented on 11/29/2025 Licensed Practical Nurse #6 was doing their routine rounds, they walked through A pod, then B pod on the Coldspring unit, entered the second-floor stairwell E at 3:30 AM and found Resident #4 at the landing of the first-floor stairway with their wheelchair on top of them. Registered Nurse #4 Nursing Supervisor was called, assessed Resident #4 and stated all vitals were stable; Resident #4 had a gash to their right hand and left side of forehead, and an abrasion on their right knee. The ambulance was called, and Resident #4 was sent to the hospital to be evaluated. Security Officer #1 documented they reviewed security camera footage which revealed Resident #4 had exited their room at 2:40 AM and attempted to open other residents' doors and stairwell E door (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but was unable to. At 2:50 AM, Resident #4 was able to kick open stairwell E door and passed through to the stairwell. At 3:34 AM, Licensed Practical Nurse #6 was seen going through the door. Registered Nurse #4 and Licensed Practical Nurse #6 opened stairwell E door multiple times to test the alarm and both stated it only activated once. Review of written statements from staff working at the time of Resident #4s elopement on 11/29/2025 documented as part of the facility's investigation revealed the following:-Licensed Practical Nurse #6 documented they did not witness the fall, they entered stairwell E and found Resident #4 at the bottom of the stairs, alerted Registered Nurse #4.-Certified Nurse Aide #8 (Resident #4s assigned aide) documented they did their rounds at 1:00 AM and Resident #4 was in their bed. Certified Nurse Aide #8 documented they sat in the middle of the two pods to listen for lights on both sides because Certified Nurse Aide #9 was gone for a while.-Licensed Practical Nurse #1 documented they were notified by Certified Nurse Aide #8 that they completed their rounds at 1:00 AM and Resident #4 was in bed. At 3:30 AM, Licensed Practical Nurse #6 alerted them to Resident #4 being in the stairwell.The Work Order Details form dated 11/29/2025 at 5:32 AM revealed Registered Nurse #4 submitted a work order for stairwell E due to security door alarm malfunctioning. A resident was able to get out of the door. There was no prior work orders submitted for the stairwell E door.During an observation of A pod stairwell E on 02/18/2026 at 3:40 PM, Licensed Practical Nurse #7 pushed the door handle and opened the stairwell door, the alarm sounded. The alarm was loud and there was no wander guard alarm.During intermittent observations from 02/18/2026 to 02/20/2026 between 8:00 AM and 4:00 PM, Resident #4 was lying in their bed in their room. Resident #4 was noted to have a wander guard to their left wrist. There were no observations that the resident had exit seeking behavior.During an interview on 02/18/2026 at 1:39 PM, Registered Nurse #4 Nursing Supervisor stated they were alerted to Resident #4 being in the stairwell on 11/29/2025, they assessed Resident #4 who had no complaints, just wanted to go to work. They stated Resident #4 had a wander guard on, but security did not receive an alert that Resident #4 had exited through the door; they tested the door following the incident multiple times, and it only alarmed once. They put in a work order that morning for the door to be checked. Registered Nurse #4 stated Resident #4 returned from the hospital the same day and was placed on the third floor, which was a more secure unit, had not had any elopements since their return.During a telephone interview on 02/18/2026 at 2:08 PM, Certified Nurse Aide #8 (Resident #4's assigned aide) stated they worked on 11/29/2025 and were assigned to the B pod. They stated the double doors were closed entering B pod from A pod at the beginning of the shift, they did not know why, so they remained closed. They stated they did their checks on residents every two (2) hours, and sat at the desk in between the two pods, outside the double doors, throughout the night. Certified Nurse Aide #8 stated they last saw Resident #4 at 1:00 AM in bed sleeping. Certified Nurse Aide #8 stated a call light went off at 2:00 AM so they went to assist a resident on A pod and then returned to the desk in between the pods. Certified Nurse Aide #8 stated they did not hear a door alarm go off, but it was possible they could not have heard it because they were on the opposite end of the unit, the double doors were closed, and another call light was ringing.During a telephone interview on 02/18/2026 at 2:19 PM, Certified Nurse Aide #9 stated they worked on 11/29/2025, did not hear any alarms go off and did not provide care for Resident #4 at all.During an interview on 02/19/2026 at 10:02 AM, Licensed Practical Nurse #3/ Unit Manager stated there was an incident in November where Resident #4 had gotten into the stairwell through the stairwell E exit. They stated the doors on the second floor did not have badge access swipes to get through them, so they did not alarm when a resident with a wander guard passed by or through them, and did not alert security when a door alarm went off; the doors would alarm when opened without pushing the two red buttons located at the top of the door. They stated Resident #4 was always busy and had multiple falls due to self-transferring, but no prior elopement attempts. Licensed Practical Nurse #3 stated they do not know why the double doors were closed, would have expected staff to open them so they could keep eye on all residents if needed.During an interview on 02/19/2026 at 12:34 PM, the Director of Nursing stated they were not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware of any complaints about the door alarm to stairwell E malfunctioning until after Resident #4 eloped through it, and even after that there was not anything wrong with the system. The Director of Nursing stated the stairwell doors on the second floor did not have badge swipes, magnetic locks, or wander guard alert systems on them; only doors with magnetic locks would alert security if accessed without a badge swipe.During an interview on 02/19/2026 at 2:00 PM, the Director of Nursing stated they reviewed the surveillance footage from 11/29/2026 and they were unable to determine if the door alarm sounded or not, there was no audio to the video.During a telephone interview on 02/19/2026 at 2:40 PM, Licensed Practical Nurse #1 stated during the 11:00 PM to 7:00 AM shift on 11/28/2025 they primarily worked on A pod throughout the shift. They stated that around 2:00 AM they were assisting residents on A pod with Certified Nurse Aide #8. Licensed Practical Nurse #1 stated they did not hear a door alarm sound. Licensed Practical Nurse #1 stated Licensed Practical Nurse #6 passed by the nurses' station and then shortly after they came back and let them know Resident #4 was in the stairwell.During an interview on 02/19/2026 at 3:35 PM, Licensed Practical Nurse #6 stated they entered stairwell E while coming back from their break and found Resident #4 lying at the bottom of the stairwell with their wheelchair on top of them; they stated Resident #4 said they were going to work and could not be late and did not complain of any pain. Licensed Practical Nurse #4 stated they called Registered Nurse #4 Nursing Supervisor, who came and assessed the resident. After Resident #4 was taken to the hospital, Licensed Practical Nurse #4 stated they opened the door by pushing on the handle with Registered Nurse #4 Nursing Supervisor present multiple times and the door alarm only sounded once.During an interview on 02/20/2026 at 8:44 AM, the Director of Nursing stated they determined Resident #4 was able to get into the stairwell and fall down the stairs because the staff assigned to care for them was caring for other residents. They stated they determined through surveillance footage that the double doors were closed in between A and B pod, so there was a possibility the door alarm was not heard because staff were in a resident's room, but they could not say for sure. The Director of Nursing stated they would have expected for staff to have had the double doors open at the beginning of the shift so they could hear anything that was going on in either pod; it was important to ensure residents safety.During an interview on 02/20/2026 at 9:14 AM, the Administrator stated the door alarms only sounded locally on the second floor; they would expect it to be difficult to hear the door alarm sound on the second floor if staff were in the other pod with the double doors closed, especially on the overnight shift because there were less staff present. That was one reason they requested magnetic locks on those doors. The Administrator stated they would have expected staff to communicate and monitor the residents.During a telephone interview on 02/20/2026 at 12:03 PM, the Manager of Physical Environment Compliance stated following the elopement on 11/29/2025, a work order was placed regarding stairwell E door on the second floor. The door was assessed and it was determined it was not an alarm issue. The following day a carpenter was called out and inspected the door and said the door was working as designed.During a telephone interview on 02/20/2026 at 1:19 PM, Nurse Practitioner #1 stated they saw Resident #4 when they returned from the hospital after falling in a stairwell. They stated upon their assessment Resident #4 had some scabbed areas and was not complaining of any pain. Nurse Practitioner #1 stated they would have expected staff to do routine rounding, hourly if possible, to make sure all residents' needs were met. They stated if a resident had any concern with prior elopement attempts, they expected staff to check on them frequently.2. Resident #5 had diagnoses including congenital alveolar hypoventilation syndrome (rare neurological disorder characterized by inadequate breathing during sleep), epilepsy (seizures), and tracheostomy status (surgical intervention that establishes an airway through an incision in the neck into the trachea). The Minimum Data Set, dated [DATE] documented Resident #5 was severely cognitively impaired, was rarely/never understood, rarely/never understands, and did not exhibit wandering behavior.The comprehensive care plan dated 01/16/2025 documented Resident #5 was to be supervised in their room and on the unit when ambulating. There was no documentation that the resident had exit seeking behaviors or was at risk (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highpointe on Michigan Health Care Facility	1031 Michigan Ave Buffalo, NY 14203

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for elopement.Review of the Kardex Report dated 05/04/2025 documented Resident #5 was independent for bed mobility and required supervision from staff for ambulation (walking), Resident #5 received schooling weekly when school was in session; staff were to anticipate and meet the resident's needs.Review of weekly rounding progress note dated 03/04/2025 at 3:22 PM, the Medical Director documented Resident #5's behaviors off their ventilator had been a concern, was noted to be out of their room twice over the previous weekend. The plan was to continue to monitor behaviors closely and assess any additional safety measures that need to be put into place.Review of a Plan of Care note dated 03/05/2025 at 11:28 AM, Social Worker #1 documented therapy staff had stated Resident #5 was more engaged in therapy and their legs were becoming more stable.Review of nursing progress note dated 04/22/2025 at 6:05 AM, Registered Nurse #8 documented Resident #5 pulled off their sensor (an electronic health monitoring system) and attempted to run off the unit during evening rounds the evening prior (04/21/2025). Resident #5 was seen by staff and redirected back to their room without incident. The door to the unit had not been latching completely, Plant Operations were notified via work order.Review of 24-hour report sheets dated 04/21/2025 to 05/03/2025 revealed no documentation that staff were monitoring Resident #5 for exit seeking behavior.Review of interdisciplinary progress notes dated 04/23/2025 to 05/03/2025 revealed no documented evidence of exit seeking or wandering behavior for Resident #5.Review of Resident #5's Elopement Risk Scales documented on 02/15/2025 Resident #5 was not at risk for elopement. There was no documented evidence that a new elopement risk scale was completed for Resident #5 following the exit seeking behavior on 04/21/2025 and prior to their elopement on 05/04/2025.Review of the facility Investigation Report dated 05/04/2025 at 9:30 AM documented Resident #5 left the building at 9:19 AM through the same double door they used to get to the school bus. Environmental Service Staff #1 was coming back from their break and saw Resident #5 go through the doors. Environmental Service Staff #1 ran to Resident #5, who was on the sidewalk near the building; brought Resident #5 back into the building through the front door, and they were back on their unit by 9:21 AM. A wander guard was immediately placed on Resident #5, and they were placed on 1:1 monitoring for three days. A cover was to be placed over the push button to deter all ambulatory residents from easily assessing the push button for the double doors.Multiple observation from 02/18/2026 to 02/20/2026 from 8:00 AM to 4:00 PM, Resident #5 was in their room lying in bed and walking around their room; their wander guard was noted to their right wrist.During an interview on 02/19/2026 at 10:17 AM, Registered Nurse #9 (Resident #5's assigned nurse) stated they were on their break when Resident #5 went through the double doors. They stated the resident was lying in their bed when they saw them 15 minutes prior to taking their break. They had no knowledge of any prior exit seeking behavior. During a telephone interview on 03/05/2026 at 9:53 AM, Registered Nurse #8 stated they recalled on 04/21/2025 at the start of the evening shift (6:00 PM) one of the double doors to the unit was propped open because the buzzer that went off when the door opened was beeping nonstop. They asked if anyone had put a work order in for the malfunctioning door and then shut the door. They stated it was not safe to have the door propped open. Registered Nurse #8 stated the shift had just started, and they had just gotten report from the outgoing nurse and was in another resident's room. They heard the beeping indicating that someone was not connected to their sensor (electronic health monitoring system), came out of the room, looked down at the hall and saw Resident #5 running towards the door to exit the unit. Certified Nurse Aide #17 was standing near the doors and redirected Resident #5 back to their room, they never made it off the unit. Registered Nurse #8 stated it was a new behavior for Resident #5 as they were recently transitioned into a regular floor bed from a Posey bed (special fully enclosed hospital bed) and had been making progress with walking; was learning new skills in school and with therapy. Registered Nurse #8 stated they updated Registered Nurse #10/Nursing Supervisor, documented it in the progress notes, and thought they added it to the 24-hour report sheet. They stated they verbally updated on coming shift at 6:00 AM on 04/22/2025. Registered Nurse #8 stated they put a work order into Plant Operations regarding the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	door not latching and making a beeping noise. Someone from Plant Ops came out and serviced the door in the middle of the night but stated they needed to order a part. They stated Resident #5 was given their medication shortly after rounds and slept throughout the night without incident. Registered Nurse #8 stated typically after a resident made an elopement attempt a wander guard would be placed, and that did not happen.During a telephone interview 03/05/2026 at 11:39 AM, Registered Nurse #6 (oncoming nurse on 04/22/2025) stated they remembered being told Resident #5 had an elopement attempt on 04/21/2025 and there was a work order placed for the door during rounds on 04/22/2025 at 6:00 AM. They stated there was not a Unit Manager on the unit at the time of the elopement attempt, so the Nursing Supervisor would have been responsible for initiating any interventions and completing a new elopement risk scale. Registered Nurse #6 stated they did not recall any new intervention put into place following Resident #5's elopement attempt on 04/21/2025 and could not recall if the provider was made aware. Registered Nurse #6 stated Resident #5 should have had a wander guard placed for their safety after their exit seeking behavior on 04/21/2025, it could have prevented them from eloping on 05/04/2025. During a telephone interview on 03/05/2026 at 11:53 AM, the Former Assistant Director of Nursing/Former Interim Unit Manager stated they were on vacation until 04/23/2025 and upon their return were not made aware of Resident #5's exit seeking behavior. They stated if they would have been made aware they would have placed a wander guard on Resident #5 and completed a new elopement risk scale; the wander guard could have prevented Resident #5's elopement on 05/04/2025 from occurring. They stated since they were not there the incident should have been reported to the Nursing Supervisor or Director of Nursing so that appropriate interventions could have been put into place.During an interview on 03/05/2026 at 12:02 PM, the Director of Nursing reviewed Resident #5's electronic medical record including their progress notes from 03/04/2025 to 05/04/2025, comprehensive care plan, and elopement risk and they were not made aware of Resident #5's elopement attempt in April; they would have expected staff to document it on the 24-hour report sheet so that oncoming staff were aware, report it to their unit manager or nursing supervisor so they could follow up, and let security know so they could have placed a wander guard. The Director of Nursing stated if Resident #5 was wandering and trying to get through doors, an elopement assessment and a wander guard placement would be expected. They did not see any new interventions put into place and did not see an elopement risk scale completed after the elopement attempt on 04/21/2025, and there should have been. It was important to ensure residents' safety and could have possibly prevented any further elopements. During an interview on 03/05/2026 at 1:36 PM, Respiratory Therapist #1 stated (on 05/04/2025) they were in the back of the unit, heard the system alert and it showed Resident #5 was disconnected from their sensor. They stated they went to Resident #5s room and saw they were not in their room. They started walking towards the doors and saw Environmental Service Staff #1 walking Resident #5 back onto the unit.During an interview on 03/05/2026 at 1:18 PM, Social Worker #1 stated Social Workers were responsible for completing elopement risk scales annually, quarterly, and as needed; they were not made aware of any elopement attempt from Resident #5 in April of 2025 and would have completed a new assessment if they were made aware. They did recall Resident #5 having new behaviors due to learning new skills with school and therapy, they were progressing very fast. They stated Administration should have been made aware of the elopement attempt and a wander guard should have been applied after that attempt, that would have triggered them to complete the assessment. Social Worker #1 stated it was important to ensure the safety of residents; Resident #5s elopement on 05/04/2025 could have been avoidable if the wander guard was placed when the wandering behaviors started (on 04/21/2025).During an interview on 03/05/2026 at 1:45 PM, the Director of Nursing stated Resident #5 was hooked up to the sensor, so when the sensor was removed or detached, it would alarm at a computer screen at the nurses station and staff were trained to run when it went off, so there was a way for staff to be aware Resident #5 was out of their room.During a telephone interview on 03/05/2026 at 1:47 PM, the Medical Director stated they were noticing (continued on next page)

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