STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335172	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Comprehensive Rehab & Nursing Ctr at Williamsville	147 Reist Street Williamsville, NY 14221

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during a Complaint investigation (Complaint #NY00374344-635063) the facility did not ensure physician orders for the resident's immediate care were in place on admission for one (1) (Resident #7) of three (3) residents reviewed for admission orders. Specifically, Resident #7 was re-admitted to the facility on [DATE] and their admission medication orders were not entered into the electronic medical record and implemented until 09/10/2025.The finding is:The policy and procedure titled Electronic Physician Orders (Create, Confirm, Processing Orders) dated 08/28/2024, documented Admission/readmission orders for the care of a resident are received from a Licensed Physician/Nurse Practitioner/Physician Assistant upon admission/readmission of a resident to the facility. Orders will either be entered into the electronic medical record system by the nurse/pharmacist following confirmation from the Practitioner or directly entered by the medical provider. The nurse/pharmacist will communicate with the ordering provider when the data entry process is complete to alert the provider to electronically sign.Resident #7 had diagnoses that included schizophrenia, anxiety disorder, and hypertension. The Minimum Data Set (a resident assessment tool) dated 09/08/2025 documented an entry tracking record and was still in progress with no resident additional information.The comprehensive care plan documented there was a care plan focus initiated on 07/05/2019 for alteration in cardiac status related to hypertension, hyperlipidemia, obesity, and edema. Additionally, potential for alteration in mood was initiated on 07/05/2019 related to depression, schizophrenia, and bipolar disorder. Interventions included to administer medications as ordered and to monitor for side effects and effectiveness. The base line care plan was not provided.Review of the hospital Discharge summary dated [DATE] documented Resident #7's discharge medications: acetaminophen (Tylenol) 650 milligrams by mouth every four hours as needed; amlodipine (blood pressure medication) 7.5 milligrams by mouth every day; aripiprazole (antipsychotic medication) 30 milligrams by mouth every day; aspirin 81milligrams by mouth every day; bisacodyl suppository (laxative)10 milligrams rectally every day as needed; Vitamin D-3 (supplement) 25 micrograms two tablets by mouth every day; cholestyramine 4 gram packet by mouth every day; clonazepam (anti-anxiety medication) 0.5 milligrams by mouth every day; Vitamin B-12 (supplement) 500 micrograms by mouth every day; dicyclomine (medication used to treat irritable bowel syndrome) 20 milligrams by mouth four times a day; famotidine (medication used to treat heartburn) 20 milligrams by mouth every day; finasteride (medication for enlarged prostate gland) 5 milligrams by mouth every day; furosemide (diuretic) 20 milligrams two tablets by mouth every day; loperamide (used to treat diarrhea) 2 milligrams by mouth every two hours as needed; losartan (blood pressure medication) 25 milligrams by mouth every day; melatonin (supplement for sleep) 5 milligrams by mouth every day at bedtime; metoprolol succinate (blood pressure medication)100 milligrams by mouth every day; oxcarbazepine (seizure medication) 300 milligrams by mouth every day; oxybutynin (bladder medication) 300 milligrams by mouth twice a day; artificial tears 1.4(%) percent ophthalmic eye drops to both eyes twice a day; simvastatin (cholesterol medication) 20 milligrams by mouth every day at bedtime; tamsulosin (medication for enlarged prostate gland) 0.8 milligrams by mouth every day at bedtime; tolterodine (bladder medication) 4 milligrams by mouth every day; and trazadone (antidepressant) 100 milligrams by mouth every day at bedtime.Review of the Health Status Note dated 09/09/2025 at 10:15 AM entered as late entry by Licensed Practical Nurse Unit Manager #1, documented Resident #7 returned to the facility on [DATE] at 15:04 PM (3:04 PM), they were alert and oriented to self and surroundings, and made their needs known. Licensed Practical Nurse Unit Manager #1 further documented discharge instructions were clear, recommended medication changes and were given to the provider for further review.Review of the Telephone/Verbal Order Signature Details report dated 09/01/2025 - 09/30/2025 revealed Resident #7's medication orders were not entered into the electronic medical record until 09/10/2025 and were electronically signed by the medical providers on 09/10/2025 at 11:44 AM, 12:22 PM, 12:28 PM, 3:14 PM and 4:19 PM.Review of the Medication Administration Record dated 09/01/25 - 09/30/2025 documented Resident #7 had not receive any medications until 09/10/2025. During an observation and interview on 09/10/2025 at 9:10 AM, Resident #7 was observed sitting up at the side of their bed, appeared well-kempt and in no distress. Resident #7 stated they had returned from the hospital on Monday 09/08/2025 sometime in the evening, they received their morning medications from the hospital prior to being re-admitted but had not receive any further medications after they arrived at the