

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/15/2025
NAME OF PROVIDER OR SUPPLIER Comprehensive Rehab & Nursing Ctr at Williamsville		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review during a Complaint investigation (#NY00372469), the facility did not ensure a resident's right to be free from misappropriation of resident property for one (1) (Resident #1) of three (3) residents reviewed. Specifically, Resident #1's bank/credit card was reported missing and had fraudulent charges made by a staff member. The finding is: The policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, dated 01/20/2025 documented misappropriation of resident property included theft, unauthorized use or removal of a resident's personal property including but not limited to money, and other possessions and articles belonging to the resident regardless of monetary value. Resident #1 had diagnoses including chronic obstructive pulmonary disease, atrial fibrillation (irregular heart rate), and general anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 02/21/2025 documented the resident had moderately impaired cognition. Review of the comprehensive care plan dated 01/07/2022 revealed Resident #1 was independent for meeting their emotional, intellectual, physical, and social needs. There was no documentation that addressed safekeeping of the resident's personal items. The ACTS (Aspen Complaints/Incidents Tracking System) Complaint/Investigation Report dated 02/19/2025 documented the former Director of Nursing submitted a report on 02/18/2025 at 4:42 PM that Resident #1's daughter reported the resident's credit card had unknown charges. The resident had found their wallet on the floor and noted their card was missing. The resident's daughter called the police and filed a report. The investigation was ongoing; the former Director of Nursing and Human Resources staff went to review video surveillance at the police station and identified a Certified Nurse Aide #1 with an unidentified male. The report documented there was reasonable cause to believe that abuse, neglect or mistreatment occurred. The Police Report dated 02/07/2025 at 12:51 PM documented the officer responded to the facility for complaint of a stolen credit card and driver's license. Resident #1 believed they were taken by a staff member but did not see who took their property. They did not have any visitors and had only seen staff members enter their room between 02/02/2025 and 02/04/2025 when they believed the items were taken. Resident #1 last knew they had their credit card in their possession on 02/02/2025 at 6:00 PM, when they returned from having dinner with their daughter. They found their wallet on the floor of their room on 02/04/2025 around 6:00 PM and when they picked it up, they noticed their driver's license and credit card were removed. Resident #1 contacted their daughter, who contacted the bank to let them know of the theft and to cancel the credit card. The fraudulent charges were noted on 02/04/2025 at apparel stores for a total loss of \$1,041.41. The offender was identified as Certified Nurse Aide #1. During an observation and interview on 09/08/2025 at 11:40 AM, Resident #1 was lying in their bed, watching television. Resident #1 stated their credit/bank card was stolen, sometime over this past winter. They stated they didn't know who took it, but it was probably someone who worked at the facility, someone who knew where their things were and their routine. Resident #1 stated it was taken from their room; it was in their wallet located in their purse. The resident stated they had a drawer with a lock, but they never received a key for it, and they would have used the drawer if they had a key. The resident's purse was observed attached to their rolling walker next to their bed. During an interview on 09/09/2025 at 11:40 AM, the Interim Director of Nursing stated they considered stealing a credit card a misappropriation of resident's items which was a form of abuse. They stated this was the resident's home and that some people lose sight of that. During a telephone interview on 09/09/2025 at 12:23 PM, Certified Nurse Aide #1 stated they started working at the facility in January. They stated when they left work either on 02/03/2025 or 02/04/2025 a coworker asked them for a ride home. The coworker asked Certified Nurse Aide #1 to drive them to a clothing store because they needed something to wear for a funeral. Certified Nurse Aide #1 stated the coworker told them their clothing size and gave them a credit card to use in the store. Certified Nurse Aide #1 stated they didn't look at the name on the credit card and they wouldn't have known it was a resident's name if they had looked because they only worked at the facility a short time and didn't know everyone's name yet. Certified Nurse Aide #1 stated nobody from the facility contacted them about this and they found out when the police showed up at their house sometime after February 20th (2025). Certified Nurse Aide #1 denied taking the credit card and stated they had a lawyer, and their court date was soon. During an interview on 09/09/2025 at 1:10 PM, the Administrator stated this stolen credit card incident did not sound familiar to them. They stated credit card theft was considered misappropriation if it was founded. The Administrator stated everything was an allegation until it was proved or disproved, they did not know if this situation was proven, and they should have known. They</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review conducted during a Complaint investigation (#NY00372469) the facility did not have evidence that all alleged violations of misappropriation were thoroughly investigated, that the results of all investigations were reported to the state agency within 5 working days of the incident, and that corrective actions were taken for the verified alleged violation for one (1) (Resident #1) of three (3) residents reviewed. Specifically, the facility did not complete an investigation of an alleged theft of Resident #1's credit card, did not report the results within 5 working days of the incident, and did not take corrective actions when the allegation was verified. In addition, the facility did not ensure their policy for abuse investigation and reporting was current. The finding is: The policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, dated [DATE] documented misappropriation of resident property included theft, unauthorized use or removal of a resident's personal property including but not limited to money, and other possessions and articles belonging to the resident regardless of monetary value. Facilities must document that the allegations are thoroughly investigated, including any incident that is not consistent with routine operation of the facility or routine care of the resident. The supervisor who has been informed of the allegation is to complete the initial investigation report and forward a copy to the Administrator. Resident #1 had diagnoses including chronic obstructive pulmonary disease, atrial fibrillation (irregular heart rate), and general anxiety disorder. The Minimum Data Set (a resident assessment tool) dated [DATE] documented the resident had moderately impaired cognition. Review of the comprehensive care plan dated [DATE] revealed Resident #1 was independent for meeting their emotional, intellectual, physical, and social needs. There was no documentation that addressed safekeeping of the resident's personal items. The ACTS (Aspen Complaints/Incidents Tracking System) Complaint/Investigation Report dated [DATE] documented the former Director of Nursing submitted a report on [DATE] at 4:42 PM that Resident #1's daughter reported the resident's credit card had unknown charges. The resident had found their wallet on the floor and noted their card was missing. The resident's daughter called the police and filed a report. The investigation was ongoing, the former Director of Nursing and Human Resources staff went to review video surveillance at the police station and identified a Certified Nurse Aide #1 with an unidentified male. The Certified Nurse Aide had been removed from the schedule within the last two (2) weeks because their certification expired prior to the resident's daughter reporting this incident. The report documented there was reasonable cause to believe that abuse, neglect or mistreatment occurred. The Police Report dated [DATE] at 12:51 PM documented the officer responded to the facility for complaint of a stolen credit card and driver's license. Resident #1 believed they were taken by a staff member, but did not see who took their property. They did not have any visitors and had only seen staff members enter their room between [DATE] and [DATE] when they believed the items were taken. Resident #1 last knew they had their credit card in their possession on [DATE] at 6:00 PM, when they returned from having dinner with their daughter. They found their wallet on the floor of their room on [DATE] around 6:00 PM and when they picked it up, they noticed their driver's license and credit card were removed. Resident #1 contacted their daughter, who contacted the bank to let them know of the theft and to cancel the credit card. The fraudulent charges were noted on [DATE] at apparel stores for a total loss of \$1,041.41. The offender was identified as Certified Nurse Aide #1. During an observation and interview on [DATE] at 11:40 AM, Resident #1 was lying in their bed, watching television. Resident #1 stated their credit/bank card was stolen, sometime over this past winter. They stated they didn't know who took it, but it was probably someone who worked at the facility, someone who knew where their things were and their routine. Resident #1 stated it was taken from their room; it was in their wallet located in their purse. The resident stated they had a drawer with a lock, but they never received a key for it, and they would have used the drawer if they had a key. During an interview on [DATE] at 3:39 PM, the interim Director of Nursing stated they could not find an accident and incident report regarding the stolen credit card and the Administrator didn't have anything either. During an interview on [DATE] at 11:40 AM, the Interim Director of Nursing stated they would have expected an incident report to be completed regarding the missing credit card. The former Director of Nursing should have been the one to complete it. The investigation should have included statements from the resident and roommate, any witnesses like Certified Nurse Aides, Unit Manager. The Director of Nursing should have notified the Administrator about the situation and should have called the police. During a telephone interview on [DATE] at 12:23 PM, Certified Nurse Aide #1 stated they</p>		