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 01/08/2026

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not follow the required transfer or discharge process for three (3) of three (3) residents (Residents #3, #4, and #5) reviewed for Transfer or Discharge Process. Specifically, the facility did not notify the residents and the residents' representatives in writing and did not send a copy of the notice to the representative of the Office of the State Long-Term Care Ombudsman at least 30 days before the resident was transferred or discharged . The findings are:The policy and procedure titled Discharge Plan - Discharge Instructions revised 12/03/2025 documented it was to provide each resident that had an anticipated discharge date with the necessary information and connections to outside services to ensure the safest discharge. It documented that each department was to interview the resident and continuing care provider prior to the anticipated discharge to assess continued care needs as well as develop a plan designed to ensure the resident's needs will be met after discharge.1.Resident #3 had diagnoses that included dementia, type II diabetes mellitus, and depression. The Minimum Data Set (a resident assessment tool) dated 10/13/2025 documented Resident #3 was always understood, always understands, and was cognitively intact. The Minimum Data Set indicated there was no active discharge plan. A progress note by Social Worker #1 dated 11/17/2025 at 2:56 PM, documented that Social Worker #1 spoke with Resident #3's representative early last week and made them aware that the facility was planning to laterally discharge Resident #3 to another facility with a more secure lock down unit. It further stated that the resident and representative were both made aware that the resident would be transferring to the first facility with an open bed. This was the only note entered by Social Worker #1 regarding any discharge planning for Resident #3. 2.Resident #4 had diagnoses that included dementia, bipolar disorder (a serious mental illness causing extreme shifts in mood, energy, and activity levels), and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 09/12/2025 documented Resident #4 was always understood, always understands, and was cognitively intact. Resident #4 was discharged on 11/14/2025 and the discharge notice was completed and dated 11/13/2025 by Social Worker #1. The signature line for the resident was blank. 3.Resident #5 had diagnoses that included polyneuropathy (a condition where multiple peripheral nerves outside the brain or spinal cord are damaged causing wide-spread symptoms like numbness, tingling, weakness, and burning pain), bipolar disorder, and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 10/16/2025 documented Resident #5 was usually understood, always understands, and was moderately cognitively impaired. A progress note by Social Worker #1 marked as a late entry and effective 11/17/2025 at 9:09 AM that documented the writer notified this resident of discharge and gave them the discharge notice and summary upon discharge. Resident #5 was discharged on 11/14/2025 and subsequently re-admitted on [DATE] after filing an appeal. Their discharge notice was completed and dated 11/13/2025 by Social Worker #1 and the signature line indicated Verbal Consent where Resident #5's signature was required.During an interview on 01/07/2026 (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 9:10 AM, Social Worker #1 stated that Resident #3 had been discharged because they required a more secure unit, due to their dementia diagnosis and because they had been wandering throughout the facility. When asked for documentation of Resident #3's wandering behaviors, Social Worker #1 searched through the facility's electronic medical records system and was unable to locate any recent documentation, or recent wandering /elopement assessments. Social Worker #1 state they did not know why Section Q of Resident #3's minimum data set, completed on 10/13/2025 indicated there was no active discharge planning for this resident. Social Worker #1 then stated that someone must have told them Resident #3 was at risk for elopement due to wandering but was unable to remember who that someone was.Social Worker #1 stated they believed they spoke with Resident #3's representative on 11/11/2025 to inform them that Resident #3 would be discharged to another facility. They gave the representative time to research two facilities with lock-down units and the representative got back to them either the following day or the day after with their choice. The representative requested Social Worker #1 call them prior to the move to ensure they would be able to be at the facility to assist Resident #3 with the move. Social Worker #1 stated they did not call the representative prior to the move and only spoke with Resident #3 on 11/13/2025 to inform them that they were going to be moving, stating the resident was pretty okay with the move. Social Worker #1 stated that the aides on the unit packed Resident #3's belongings and that after the move, the resident's representative left a message for Social Worker #1 stating they had filed a complaint as they were not notified of the timing of Resident #3's move and had not received a written Transfer/Discharge notice. Social Worker #1 stated they left a message back to the representative apologizing on 11/17/2025 but never connected with Resident #3's representative. They stated, I sent a Transfer/Discharge notice to the Ombudsman and we discharged two other residents to that same facility as Resident #3 on the same date as Resident #3 (11/14/2025). Social Worker #3 printed the email sent to the Ombudsman program notifying them of the discharges. The email was dated 11/18/2025 at 9:41 AM and stated: Attached are discharge transfer notices. I will update more frequently going forward. Thanks. Social Worker #1 furnished a copy of the notice they stated they gave to Resident #3. It was dated 11/13/2025, documented that it was necessary for the resident's welfare and their needs could not be met at this facility - lateral transfer to secure locked unit in another Skilled Nursing Facility. The line to be signed by the resident or representative was blank and Social Worker #1 signed the signature line for the social worker, both lines were dated 11/13/2025.During a follow-up interview on 01/07/2026 at 10:42 AM, Social Worker #1 stated the nutritional section of the IDT Discharge instructions dated 11/14/2025 for Resident #3 were not completed because the facility nutritionist was working part-time and likely didn't know about the discharge. He stated he had not spoken with the nutritionist about these discharges.During an interview on 01/07/2026 at 11:54 AM, the Administrator stated that if a resident was agreeable to a move, they did not need to give a transfer/discharge notice 30 days prior to the discharge and if a resident was responsible for themselves, family would not need to be notified of a transfer. The Administrator stated that the discharge summary was to be initiated by the social worker and all other disciplines/departments would receive a notice to complete their parts. The Administrator stated they expected all parts of the discharge summary in the electronic system to be completed, including the nutrition part. The Administrator stated that on 11/14/2025 three residents (Resident #3, Resident #4, and Resident #5) were transferred to the same other facility, and one filed an appeal, and this facility ended up having to take Resident #5 back, after they lost the appeal. The Administrator stated they were aware there was an issue with sending transfer and discharge notices to the Ombudsman and had since re-trained Social Worker #1 regarding this. They stated that they expected a (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharge plan to be in place, prior to a resident being transferred or discharged . The Administrator stated they would only issue a 30-day Transfer/Discharge notice to a resident who was discontent with leaving the facility.During an interview on 01/07/2026 at 1:55 PM, the facility's Ombudsman (Ombudsman #1) stated they had not been receiving discharge notices from the facility when they were made aware of the move of four of this facility's residents on 11/14/2025 to the other facility. They were the Ombudsman at the other facility as well, and received calls over the weekend, prior to 11/17/2025 from family members of residents who were moved and from the receiving facility stating that the residents were unhappy about the move. They started their day on 11/17/2025 at this facility and met with Social Worker #1 and the Administrator to inform them they had not received transfer/discharge notices for any residents since they had received one notice in July 2025. Social Worker #1 told them this recent move of the four residents had been poorly planned. Ombudsman #1 stated that residents considered for transfer/discharge and their representative should be given a written notice 30 days prior to the transfer/discharge and Ombudsman #1 should receive a copy of that notice on the same day as the resident and representative. They stated they gave the most updated Transfer/Discharge Notice form to Social Worker #1 and the Administrator and set their expectations for future notifications with Social Worker #1 and the Administrator during their meeting on 11/17/2025. They stated the forms they received for transfers and discharges that took place prior to 11/17/2025 were an outdated form that did not meet the current regulatory requirements for the written notices. Ombudsman #4 stated the facility moved a total of four residents to the other facility on 11/14/2025.During an interview on 01/07/2026 at 3:31 PM, Resident #5 stated that the facility did not tell them they were moving. They stated staff came into their room in the morning on the day of the move, packed them up and moved them. Resident #5 stated they had to beg to get back to this facility and they did not like it at the facility they had been moved to.10 NYCCR 415.3(i)(1) (i-vii)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review conducted during an Abbreviated survey (Complaint #2693403), the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (1) (Resident #1) of three (3) residents reviewed for physician orders. Specifically, Resident #1 had an order for compression for leg edema (swelling caused by excess fluid accumulation) that was not entered into the electronic medical record or implemented.The finding is: The policy titled Physician Notification dated 12/10/2024 documented that nurses are to record any new orders in the resident's medical record. The policy titled Physician Verbal and Telephone Orders documented that all new orders including admission orders are to be confirmed by medical staff via phone or during medical rounds. Resident #1 was admitted to the facility with diagnoses including heart failure, heart disease, and was cognitively impaired. The comprehensive care plan dated 10/08/2025 documented that Resident #1 was at the facility for short term rehabilitation and had altered cardiovascular status including hypertension (high blood pressure), coronary artery disease (disease that affects the main arteries leading to the heart), and atrial fibrillation (an irregular heartbeat). Review of nursing Progress Notes dated 09/17/2025 to 10/8/2025 revealed:-On 09/17/2025 at 4:23 PM, Resident #1's legs were elevated to reduce edema (swelling caused by excess fluid). -On 09/17/2025 at 7:47 PM, the resident's legs were elevated to tolerance and some swelling was noticed.-On 09/18/2025 at 10:10 PM, the resident's lower legs were elevated to tolerance with some swelling noted.-On 09/25/2025 at 8:30 PM, the resident's legs appeared more swollen than usual. An order for Lasix (medication used to treat excess fluid) was given for three days to reduce the swelling and they would be seen by the house doctor.There were no new orders for compression of any type documented for Resident #1 Review of the medical provider progress note dated 09/29/2025, the Physician Assistant documented that they ordered compression to be added to Resident #1's treatment. Review of physician orders dated 09/16/2025 to 10/09/2025 revealed that there were no orders for any kind of compression stockings, ace wraps, or other form of compression for Resident #1. Review of the Treatment Administration Record dated from 9/17/2025 to 10/07/2025 revealed there were no treatments for any type of compression for edema for Resident #1. During a telephone interview on 01/06/2026 at 12:00 PM with Licensed Practical Nurse #1, they stated that they are supposed to clarify any orders from the Physician Assistant. They stated that the Unit Manager or the Registered Nurse Supervisor are the nurses who would take the order from the Physician Assistant. They stated that if the Unit Manager is not available then the Registered Nurse Supervisor is to take care of new orders. During a telephone interview on 01/06/2026 at 12:40 PM with the former License Practical Nurse Unit Manager #2, they stated that they would often not see new orders as the providers would not give them the orders directly. They stated that they might not see new orders for a resident for a few days. They stated they did not review the provider's note and were not aware the physician assistant ordered compression for Resident #1's legs. During an interview on 01/07/2026 at 10:01 AM, the Director of Nursing stated that they expect their Unit Managers to put in new orders for residents. They stated that they would expect the Unit Manager to get a clarification for any new orders and to put new orders in by the end of the day. They stated this order should have been implemented for the resident. During an interview on 01/07/2026 at 10:38 AM, the Administrator stated that they would expect the Unit Manager or the interdisciplinary team to have the orders clarified. They stated that the orders should have been entered within 24 hours. During a telephone interview on 01/07/2026 at 11:46 AM with the former Registered Nurse Supervisor #1, that stated that the Physician Assistant would leave the new orders for residents and not give them to the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit Manager. They stated they expect new orders to be put in right away. They stated that the new orders should be put in by the Unit Manager and, if the Unit Manager is not available, then the Registered Nurse Supervisor should put the new orders in. They stated that yes, these new orders should have been put in. During a telephone interview on 01/08/2026 at 7:46 AM with the former Physician Assistant stated that they would expect the order to be entered for the resident as soon as possible. They stated that if there were any problems with the order, a nurse should have clarified the order. They stated the order should have put in for compression. They stated that they wanted ace wraps for the resident, and they should have written that. They stated that at the time, providers could not put in their own orders with the facility's electronic medical record. They stated they did not communicate the order for compression to the nursing staff. 10 NYCRR 415.12