STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335647	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsville Suburban, L L C	163 South Union Road 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 0600 Level of Harm - 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** 36415 Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint #NY00331630), the facility did not ensure residents had the right to be free from physical abuse for one (Resident #1) of three residents reviewed. Specifically, on 1/16/2024 resident to resident physical abuse occurred between Resident #1 and Resident #2. Resident #2 grabbed Resident #1's arm and aggressively threw Resident #1 down to the floor. Resident #1 experienced pain; sustained a compression fracture (small breaks in the spine) of T2 (the upper aspect of thoracic region (middle section of spine) and fractures (break) of the left elbow and hip. Resident #1 was subsequently transferred to the hospital. This resulted in actual harm to Resident #1 that is not immediate jeopardy. The finding is: The policy and procedure titled Abuse, Neglect and Exploitation of Residents with a review date of 2/23 documented that each resident has the right to be free from physical abuse. Residents will not be subjected to abuse by anyone, including but not limited to other residents. The definition of physical abuse was the inappropriate physical contact with a resident which harms or was likely to harm the resident. This included but was not limited to, hitting, slapping, pinching, spitting at, and kicking. Resident #1 had diagnoses which included advanced dementia, depression, and anxiety. The Minimum Data Set (a resident assessment tool) dated 1/5/2024 documented Resident #1 had severe cognitive impairment, was rarely understood, and rarely understands. The resident ambulated independently and wandered daily. The comprehensive care plan identified as current by covering Licensed Practical Nurse Unit Manager #3 dated 8/1/2023 documented Resident #1 was at risk for resident altercations related to wandering into peer's room. The goal documented the resident would be safe and free from harm by peers. Interventions included to keep Resident #1 away from other resident(s) exhibiting physical/verbal behavioral symptoms directed towards others; protect from potential harm; and redirect/refocus attention by offering alternatives. (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 - Actual harm Residents Affected - Few	Resident #2 had diagnoses which included psychosis (when people lose some contact with reality), aphasia (absence or difficulty with speech), and mood disorder. The Minimum Data Set, dated dated dated [DATE] documented Resident #2 had severe cognitive impairment, was usually understood, and usually understands. The resident had no physical behavioral symptoms directed towards others. Required partial/moderate assistance with bed to chair transfers and wheelchair mobility. The comprehensive care plan identified as current by covering Licensed Practical Nurse Unit Manager #3 dated 1/17/2022 documented Resident #2 had impaired social interactions with resident-to-resident altercation (aggressor) dated 8/17/2022. Interventions included to encourage participation in activities, psychological services as needed and private room due to aggressive behavior. Resident #2 could be physically/verbally aggressive and throws themselves onto the floor when upset. During an observation of the North 2nd Floor D Wing hallway video surveillance footage on 2/8/2024 at 8:50 AM in the presence of the Administrator revealed the following: On 1/16/2024 at 5:00 PM Licensed Practical Nurse #1 stood in the hallway at the medication cart and was engaged in a medication pass. Resident #1 came into view from the right and ambulated independently toward the nurse and the medication cart. Resident #2 came into view from the left. Resident #2 came swiftly down the hallway headed directly towards Resident #1 using their left hand on handrail and feet to self-propel their wheelchair. Resident #2 released the handrail and with their left hand forcefully grabbed ahold of Resident #1's right arm and threw them to the floor. Resident #1 bumped their head on the wall as they fell to the floor. During an interview on 2/8/2024 at 8:55 AM, the Administrator stated there was no additional surveillance footage prior to the incident. The Administrator stated based on the video surveillance footage the altercation between Resident #1 and Resident #2 was physical abuse. The Full Quality Assurance Report referred to by the Director of Nursing as the accident/incident report dated 1/16/2024 completed by Assistant Director of Nursing #1 documented Resident #1 ambulated in the hallway and was in a witnessed altercation with Resident #2. Assistant Director of Nursing #1 had documented that they were notified that Resident #1 ambulated into Resident #2's room, then walked out. Resident #2 grabbed Resident #1 and pulled Resident #1 to the floor. Resident #1 bumped their head against the wall and grimaced in pain. The nursing progress notes dated 1/16/2024 at 11:34 PM completed by Assistant Director of Nursing #2 documented Resident #1 was transferred to the hospital for evaluation at 10:30 PM. The Hospital History and Physical dated 1/17/2024 documented the computerized tomography scan (CT- a medical imaging technique used to obtain detailed internal images of the body) showed a compression fracture of T2 (thoracic spine #2). X-rays documented fractures of the left elbow and hip. Resident #1's family opted for palliative (conservative) measures. The Nursing Home Investigative Report submitted by the Director of Nursing on 1/25/2024 printed on 1/25/2024 documented there was reasonable cause to believe that abuse, neglect, or mistreatment occurred. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Williamsville Suburban, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 163 South Union Road Williamsville, NY 14221	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/8/2024 at 9:06 AM, Licensed Practical Nurse #1 stated on 1/16/2024 they looked up from the medication cart and saw Resident #1 walking towards them. Resident #2 was loudly yelling Ahh and intentionally grabbed Resident #1's right arm aggressively and yanked Resident #1 down to the floor. Licensed Practical Nurse #1 stated they were unaware of what precipitated Resident #2's aggression. Resident #1 wandered daily in and out of other resident rooms and was easily redirected. The altercation on 1/16/2024 was physical abuse, resulted in fractures, and caused harm to Resident #1. During a telephone interview on 2/8/2024 at 10:47 AM, Certified Nurse Aide #2 stated Resident #1 wandered daily in the hallway and into other resident rooms. Was always on the go and was harmless. They stated they would redirect, encourage engagement in the activities, and offered snacks. Certified Nurse Aide #2 stated Resident #2's behaviors included temper tantrums, throwing their remote control and throwing themselves on the floor to get attention. During an interview on 2/8/2024 at 12:08 PM, Assistant Director of Nursing #1 stated when Resident #2 grabbed Resident #1 by the arm, yanked them down which resulted in a fall was physical abuse. Resident #1 sustained fractures and had pain upon assessment. Any fracture would be harmful. During a telephone interview on 2/8/2024 at 2:46 PM, Medical Provider #2 stated Resident #2 hurt Resident #1. The incident was physical abuse which caused a cascade of events. Resident #2 pulled Resident #1 down to the floor, caused the fractures and then Resident #1's condition declined. The injuries were harmful to Resident #1. During a telephone interview on 2/9/2024 at 8:53 AM, Certified Nurse Aide #3 stated they were assigned to Resident #1 and #2 on 1/16/24. It was chaotic, I turned around and Resident #1 was on the floor. Resident #1 must have entered Resident #2's room which made them aggressive. During an interview on 2/9/2024 at 11:31 AM, the Director of Nursing stated physical abuse occurred when one of the party's understood the repercussions. During an interview on 2/9/2024 at 11:49 AM, the Administrator stated Resident #2 intended to cause Resident #1's fall and their actions led to serious bodily injury and harm to Resident #1. 10 NYCRR 415.4(b)(1)(i)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview and record review conducted during a complaint investigation (#NY00331620), the facility did not ensure that all alleged allegations of abuse, were thoroughly investigated for two (Resident #1 & 2) of three residents reviewed. Specifically, the facility did not complete a thorough and accurate investigation into resident-to-resident abuse to include conducting interviews with witnesses and other pertinent staff. The finding is: The policy and procedure titled Abuse, Neglect and Exploitation of Residents dated 4/19 documented the Administrator/Director of Nursing (DON/designee will conduct an investigation. Witness reports will be in writing. Witnesses will be required to sign and date such reports. The individual conducting the investigation shall follow the procedure for reporting and investigation when an incident of resident abuse is alleged or suspected. The following should be reported by individuals/employees which include the following: The name of the resident involved, the date and time the incident occurred, where the incident took place, the name of persons committing the incident, if known, the names of any witnesses to the incident, and the type of abuse that was committed. The policy and procedure titled Abuse Reporting dated 10/2022 documented should a resident be observed abusing another resident, the facility will implement the following actions: Review with the resident to determine the cause of the behavior; Evaluate the circumstances/events leading up to the incident and Perform a Root Cause Analysis to identify possible/probable cause. Resident #1 had diagnoses which included advanced dementia, depression, and anxiety. The Minimum Data Set (a resident assessment tool) dated 1/5/2024 documented Resident #1 had severe cognitive impairment. The resident ambulated independently and wandered daily. The comprehensive care plan identified as current by covering Licensed Practical Nurse #3 dated 8/1/2023 documented Resident #1 was at risk for resident altercations related to wandering into peer's room. Resident #2 had diagnoses which included psychosis (people lose some contact with reality), aphasia (absence or difficulty with speech), and mood disorder. The Minimum Data Set, dated dated dated [DATE] documented Resident #2 had severe cognitive impairment. The resident had no physical behavioral symptoms directed towards others. The comprehensive care plan identified as current by covering Licensed Practical Nurse #3 dated 1/17/2022 documented Resident #2 had impaired social interactions with resident-to-resident altercation (aggressor) dated 8/17/2022. During an observation of the North 2nd Floor D Wing hallway video surveillance footage on 2/8/2024 at 8:50 AM in the presence of the Administrator revealed Resident #2 abused Resident #1 when they forcefully grabbed ahold of Resident #1's right arm and threw them to the floor. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/8/2024 at 8:55 AM the Administrator stated, there was no camera surveillance of Resident # 1 entering or exiting Resident #2's room and stated they were told by Assistant Director of Nursing #1 that Resident #1 had entered then exited Resident #2's room which led to the altercation. The certified nurse aide assignment sheet dated 1/16/2024 documented Certified Nurse Aide #3 was assigned to Resident #1 and #2 on the 3:00 PM-11:00 PM shift. Review of the Mitigate Risk Full Quality Assurance Report the Director of Nursing referred to as the accident/incident report dated 1/16/2024 and signed by the Director of Nursing on 1/23/2024 and the Administrator on 2/7/2024 revealed that on 1/16/2024 at 5:00 PM Resident #1 was in a witnessed altercation with Resident #2. There was no documented evidence of statements or interviews conducted with witnesses, and there was no evidence the facility implemented their policy to evaluate the events leading up to the abuse. During a telephone interview on 2/9/2024 at 8:53 AM, Certified Nurse Aide #3 stated they were assigned to Resident #1 and #2 on 1/16/2024. It was chaotic, I turned around and Resident #1 was on the floor. Certified Nurse Aide #3 stated they did not provide a statement regarding the altercation or events leading the altercation. During an interview on 2/9/2024 at 10:10 AM, Licensed Practical Nurse #1 stated It was busy, and did not provide a written or verbal statement on 1/16/2024. During a telephone interview on 2/9/2024 at 10:36 AM, Licensed Practical Nurse Unit Manager #2 stated they did not see the altercation between Resident #1 and #2 on 1/16/2024. Licensed Practical Nurse Unit Manager #2 stated Assistant Director of Nursing #1 was responsible for the investigation. Statements should be gathered from all staff on the unit describing what led to the altercation. During an interview on 2/9/2024 at 10:49 AM, Assistant Director of Nursing #1 stated they were informed of a resident-to-resident altercation on 1/16/2024 at 5:00 PM. The investigation was started, and the medical providers were notified, I did not collect statements from anybody, and I should have, the focus was to take care of Resident #1. During an interview on 2/9/2024 at 11:31 AM, the Director of Nursing stated Assistant Director of Nursing #1 should have gathered statements from the certified nurse aides and floor nurses at the time of the incident. Statements would have provided perspective to the root cause of the abuse. The investigation was incomplete. During an interview on 2/9/2024 at 11:40 AM, the Regional Director of Nursing stated staff and witness statements were missing from the investigation. There was no documented evidence that Resident #1 entered or exited Resident #2's room. A thorough investigation would have included gathering witness statements from staff on the unit as far as when both residents were seen last. Statements would have helped our investigation process and determine the probable cause. It was not a complete and thorough investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/2024 at 11:49 AM, the Administrator stated Assistant Director of Nursing #1 should have collected statements from staff involved and who witnessed the incident. The investigation would be turned into the Director of Nursing who ensured all the required documentation was accurate. Without statements the investigation was not thorough. 10 NYCRR 415.4 (b)(3)