STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335650	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace View Long Term Care Facility	462 Grider Street Buffalo, NY 14215

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. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Based on video surveillance, interviews, and record review conducted during the survey, the facility failed to protect the residents from physical, mental and verbal abuse by staff for one (1) (Resident #1) of three (3) residents reviewed for abuse. Specifically, on 12/08/2025, Certified Nurse Aide #1 was observed striking Resident #1, which resulted in a red mark to the resident's cheek. Certified Nurse Aide #1 was also witnessed using profane language directed towards the resident at the time of the incident, in response to the resident's behavior. Using the reasonable person concept, as referenced on the Centers for Medicare and Medicaid Services Psychosocial Outcome Severity guide, it was determined psychosocial harm occurred as a result of the physical abuse since there is an expectation that the resident would not be slapped in the face in the facility, that is not Immediate Jeopardy.The findings are: The policy and procedure titled Abuse Prevention, Investigation and Reporting dated 04/2025 documented the facility will provide a safe, abuse free environment to residents and to comply with state and federal regulations regarding abuse prevention, investigation, and reporting. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Physical abuse included but is not limited to, hitting, slapping, and kicking. Resident #1 had diagnoses including alcoholic cirrhosis (stage of alcohol related liver disease where the liver has become significantly scarred), chronic kidney disease (kidneys damaged more than a few months), and chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs causing inflammation in airways that limit air flow into and out of the lungs). The Minimum Data Set (a resident assessment tool) dated 11/28/2025 documented Resident #1 was moderately cognitively impaired, was usually understood and sometimes understands others. Resident #1 had verbal and physical behaviors directed at others. The Closet Care Plan (guide which is placed in the residents' closet and used by staff to provide care) dated 12/07/2025 documented Resident #1 could be verbally and physically aggressive. Resident #1 was combative with hands on care and frequently attempted to self-transfer. The Closet Care Plan documented to separate and protect; report behavior changes; report altercations and provide a quiet environment. The facility investigation completed by the Interim Director of Nursing dated 12/08/2025 documented an altercation between Resident #1 and Certified Nurse Aide #1 occurred. Resident #1 was agitated and attempted to self-transfer out of the recliner. Certified Nurse Aide #1 attempted to settle Resident #1 so they would not fall again. Resident #1 then struck Certified Nurse Aide #1 in the shoulder. Certified Nurse Aide #1 responded and struck Resident #1 in the face. Certified Nurse Aide #1 immediately reported the altercation to Registered Nurse Supervisor #2. Resident #1 had a quarter-sized red mark to their left cheek which had resolved by 12/09/2025. No additional injuries were noted and no psychological harm. The facility concluded physical abuse occurred. Review of video surveillance without audio dated 12/08/2025 at 9:20 PM revealed Certified Nurse Aide #2 and Register Nurse #1 were at the nurse's station on the Canal Unit. Certified Nurse Aide #2 was sitting in a chair in front of the nurse's station looking toward the television, and Registered Nurse #1 was standing and moving about behind the nurse's station. Resident #1 was just across from the nurse's station sitting in a recliner chair with their feet elevated facing the television. Resident #1 could be seen leaning over the right side of the recliner and fidgeting with the recliner lever (handle that puts the feet up and down). Certified Nurse Aide #1 who was seated near Resident #1 at a table against the wall by the television stood up from their chair and approached Resident #1 in an attempt to re-position Resident #1. Resident #1 struck out at Certified Nurse Aide #1 making contact. Certified Nurse Aide #1 reacted by grabbing and holding the residents right wrist with their left hand and slapped Resident #1 in the face with their right hand. There was no audible sound on the video, but Certified Nurse Aide #1 appeared to say something to the resident. Registered Nurse #1 glanced over and moved around from behind the nurses' desk and left out of camera view. Certified Nurse Aide #1 quickly backed away from the resident, returned to the table against the wall for a few seconds, then left the unit and out of camera view. Review of Behavior Notes dated 12/09/2025 through 12/12/2025 documented there were no changes to Resident #1's behaviors after the altercation. During a telephone interview on 12/16/2025 at 10:24 AM, Registered Nurse #1 stated Certified Nurse Aide #1 was aggravated because the unit was hectic, and Resident #1 had fallen previously that day and kept trying to get out of the recliner. Registered Nurse #1 stated they heard a smack but did not see the slap. Registered Nurse #1 stated they heard Certified Nurse Aide #1 say Don't ever put your expletive hands on me again. Certified Nurse Aide #1 had stated Resident #1 hit them first. Certified Nurse