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	04/17/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record reviews conducted during survey, the facility failed to ensure that each residents' environment remained as free of accidents as possible and that each resident received adequate supervision and assistance devices to prevent accidents for one (1) (Resident #1) of three (3) residents reviewed for accidents. Specifically, on 09/17/2025, the facility failed to use two (2)-person bed mobility assistance, for overall rolling bed mobility, resulting in Resident #1 falling to the floor, sustaining an acute post-traumatic subdural hematoma (collection of blood that forms between the brain and its outer covering, often due to head trauma), and requiring hospitalization. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.The findings include: The facility policy titled Comprehensive Care Plan, updated 01/2026, documented the nursing home will develop and maintain a comprehensive care plan for each resident to meet a resident's medical, nursing, mental, and psychosocial needs as identified in the comprehensive assessment. The purpose was to provide a method of communication to enhance staff's ability to provide systemic, comprehensive, integrated, and coordinated care in accordance with resident's specific needs. The facility policy titled Closet Care Plan, dated 07/2025 documented the purpose was to provide a document with care instructions, ready and available in the resident's room, to any caregiver based on the comprehensive care plan. All caregivers are trained to check the closet care plan prior to assisting any resident. All caregivers assigned to care for residents are responsible for following the closet care plan. Resident #1 had diagnoses including chronic respiratory failure, nontraumatic intracerebral hemorrhage (type of stroke characterized by bleeding within the brain due to a ruptured blood vessel), and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 07/23/2025, documented the resident was comatose (persistent vegetative state/no discernible consciousness), and was dependent (helper does all of the effort, resident does none of the effort to complete the activity or the assistance of two (2) or more helpers are required for the resident to complete the activity) for the ability to roll from lying on back to left and right side. The Closet Care Plan (guide used by staff to provide care) dated 07/29/2025 documented that Resident #1 required the assistance of two (2) staff members for bed mobility (overall rolling). The Incident/Accident Form dated 09/17/2025 documented that Resident #1 fell out of bed when Certified Nurse Aide #1 was providing hands on care and rolling the resident. The Employee Statement, signed by Certified Nurse Aide #1 and dated 09/17/2025 at 9:22 AM, documented that Resident #1 fell out of bed, when they (Certified Nurse Aide #1) were providing personal/incontinent care for Resident #1. They tried to stop the fall but were unsuccessful. Certified Nurse Aide #1 documented there were no other staff members in the room when Resident #1 fell. The Human Resources Performance Improvement Form, signed by Certified Nurse Aide #1 and dated 09/23/2025 documented that Certified Nurse Aide #1 received a one (1)-day suspension. The Report Details documented on 09/17/2025 that Certified Nurse Aide #1 failed to follow the resident's care plan by providing care without the required assistance of a second staff member as outlined in the care plan. The facility policy states, All caregivers assigned to care for residents are responsible for following the Closet Care Plan and for reporting any concerns regarding its appropriateness or the need for changes to the (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 0689 Level of Harm - Actual harm Residents Affected - Few	nurse. As a result of the deviation from the care plan, the resident fell from the bed, sustained an injury, and required hospitalization. The hospital History and Physical dated 10/15/2025 documented Resident #1 presented to the emergency department on 09/17/2025 from the nursing home for evaluation of a head injury after being rolled on their left side, rolling out of bed, and striking their head on the floor. A computed topography scan (CT scan, medical imaging procedure) showed bilateral subdural hematomas and Resident #1 was admitted to the trauma intensive care unit. During an interview on 04/15/2026 at 10:58 AM, Certified Nurse Aide #1 stated on 09/17/2025, they were providing care for Resident #1 without assistance from another staff member, and the resident rolled out of the bed. They stated they were aware Resident #1 required the assistance of two (2) members but were just trying to get the resident done. During an interview on 04/15/2026 at 11:02 AM, Registered Nurse #1 Team Leader stated staff were expected to check and follow the Closet Care Plan prior to providing care. During an interview on 04/15/2026 at 11:32 AM, Licensed Practical Nurse #1 stated they responded to Resident #1's room on 09/17/2025 after the resident had fallen, they were unaware Certified Nurse Aide #1 did not have a second staff member to assist, and Certified Nurse Aide #1 did not ask them to assist with Resident #1. During an interview on 04/15/2026 at 11:47 AM, the Assistant Director of Nursing stated they expected staff to follow the Closet Care Plan and Resident #1 was injured when Certified Nurse Aide #1 did not follow the care plan. During an interview on 04/15/2026 at 11:55 AM, the Acting Administrator stated staff were expected to follow the care plan. On 09/17/2026, Certified Nurse Aide #1 did not have a second staff member assisting with the care of Resident #1. The resident fell out of bed, was transferred to the hospital, and sustained a subdural hematoma. During an interview on 04/15/2026 at 12:16 PM, the Medical Director stated they expected staff to follow protocol and the care plan. The Medical Director stated on 09/17/2025 they responded to an Adult Medical Emergency in Resident #1's room. Resident #1 was lying on the floor next to the bed and emergency medical services were called. The Medical Director also stated that the acute subdural hematomas were likely the result of the fall, and that the fall caused Resident #1 harm. 10 New York Code Rules Regulations (NYCRR) 415.12(h)(2)