Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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	08/26/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 39086 Based on observation, interview, and record review conducted during the Standard Survey completed on 8/26/24, the facility did not ensure that each resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for one (Resident #314) of six residents reviewed. Specifically, Resident #314 was observed with dark brown debris under their fingernails on both hands and eating with their hands. The finding is: The policy titled Activities of Daily Living with an effective date of 2/2024, documented individual care plan interventions will be developed and implemented to encourage self-performance at the resident's highest functional level. The policy titled Grooming, AM (morning) and PM (evening) Care with an effective date of 1/2024 documented the caregiver assigned was responsible to see that care has been given in accordance with the resident's individual plan of care. Any deviation will be reported to the nurse. AM care includes nail care. The policy titled Nail Care, effective 8/2021, documented nail care is provided weekly on bath days and as needed. Resident #314 had diagnoses that included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), alcohol abuse, and neutropenia (abnormally low white blood cell count). The Minimum Data Set) a resident assessment tool) dated 7/20/24 documented Resident #314 was moderately cognitively impaired, was sometimes understood and sometimes understands. Additionally, the Minimum Data Set documented that Resident #314 required supervision of one staff for personal hygiene and a moderate assist of one staff for bathing. The closet care plan (a guide used by staff to provide care) dated 5/14/24, documented Resident #314 required assistance from staff with grooming. Additionally, the closet care plan documented Resident #314 eats with their fingers intermittently. Review of nursing behavior notes dated 7/12/24 to 8/21/24 documented Resident #314 had no behaviors pertaining to hands on care. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER: Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/20/24 at 9:36 AM, Resident #314 was lying in bed eating a hardboiled egg with their hands. there was dark brown debris was observed under all nails on both hands. During an observation on 8/22/24 at 12:27 PM, Resident #314 was sitting at a table in the dining room eating vegetables with their hands. Resident #314's fingers went into their mouth while taking bites. Dark brown debris remained under nails on both hands. During an interview on 8/22/24 at 1:08 PM, Certified Nurse Aide #2 stated they were assigned as Resident #314's Certified Nurse Aide that morning. Certified Nurse Aide #2 stated Resident #314's morning care included nail care, but they had not provided it to them on this date. Certified Nurse Aide #2 stated nail care was provided as needed and on shower days. Certified Nurse Aide #2 then observed Resident #314's nails with dark brown debris under them and stated their nails needed to be cleaned. Certified Nurse Aide #2 stated nails should be kept clean for infection control reasons, especially if the resident eats with their hands. During an interview on 8/2/24 at 1:13 PM, Licensed Practical Nurse #4 stated Certified Nurse Aides were responsible for trimming and cleaning nails on shower days and as needed. Licensed Practical Nurse #4 stated Resident #314's nails should be cleaned every day, especially if the resident eats with their hands. It is a huge infection control issue. During a telephone interview on 8/23/24 at 10:15 AM, Registered Nurse #1 stated Resident #314 had no history of refusing nail care. Registered Nurse #1 stated they expected the Certified Nurse Aides to do nail care on shower days and as needed. Registered Nurse #1 stated it was an infection control issue to have debris under the nails, especially if the resident eats with their hands. During an interview on 8/26/24 at 10:34 AM, the Director of Nursing stated they expected staff to perform basic activities of daily living based on each resident's care plan, such as nail care. The Director of Nursing stated that if residents eat with their hands, they expected staff to wash the resident's hands and nails prior to eating. Having debris under nails while eating puts that resident at risk for developing an infection. NYCRR 415.12 (a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39086 Based on interview, and record review conducted during a Complaint investigation (Complaint #NY00321223) during the Standard survey completed on 8/26/24, the facility did not ensure each resident receives adequate supervision and assistance devices to prevent accidents for one (Resident #73) of seven residents reviewed. Specifically, Certified Nurse Aide #3 did not provide/utilize a calf board per the plan of care and the resident sustained an injury to their toe/s. The finding is: The policy and procedure titled Closest Care Plan with an effective date of 11/2019, documented the purpose of the closet care plan was to provide care instructions, ready and available in the resident's room, to any caregiver based on the comprehensive care plan team. The policy documented that all caregivers were trained to check the closet care plan prior to assisting any resident. All caregivers assigned to care for residents were responsible for following the closet care plan and to report any concerns with the appropriateness of or need for changes to the nurse. Resident #73 had diagnoses including diabetes mellitus, paraplegia (loss of motor function in the lower half of the body), and traumatic brain injury. The Minimum Data Set (MDS- a resident assessment tool) dated 7/12/23 documented the resident had moderate cognitive impairment, usually understands, and was usually understood. The Minimum Data Set documented that Resident #73 required an assist of one a few times during the 7-day look back period for locomotion. The Comprehensive Care Plan initiated on 1/11/14 documented Resident #73 documented that Resident #73 had self-care deficit and interventions included therapy screens, evaluations, and discharge summaries. The closet care plan (a guide used by staff to provide care) dated 5/9/23 documented Resident #73 was non-ambulatory and required a staff assist for wheelchair mobility in a reclining wheelchair. The closet care plan documented that Resident #73 was to have a calf support, bilateral extending leg rests when in their wheelchair. The Incident/Accident form dated 8/1/23, Licensed Practical Nurse #6 documented at 3:10 PM Resident #73 was rolling self in their wheelchair as their foot fell off the wheelchair pedal. That resulted in Resident #73's toenail to become dislodged from the big toe. It was documented that Resident #73's big toe, and second toe were bleeding. The form documented that an occupational therapy order was requested for a calf board. Review of a Progress Note dated 8/1/23 at 4:04 PM, Licensed Practical Nurse #6 documented Resident #73 was moving forward in their wheelchair as their foot fell off the pedal simultaneously resulting in the nail on their big toe to become dislodged and then bleed. Review of the OT COC Screen note dated 8/2/23 at 10:33 AM, the Director of Rehab Services documented that Resident #73 was assessed due to an incident and accident from a toe bleed. It was documented that Resident #73 was re-issued a blue foot board and black calf support. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER: Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of an untitled investigation report dated 8/8/23 at 12:53 PM, documented that Resident #73 had an injury to the nail on their left great toe that was lifted from their nail bed causing it to bleed. The investigation documented on 8/1/23 Resident #73 self-propelled to the nursing station stating they were bleeding. The investigation documented that Resident #73's great toe was bleeding and it appeared that their left leg had fallen in-between their wheelchair leg rests. The investigation documented after Resident #73 foot fell from the foot pedal, they continued to self-propelled their wheelchair, dragging their left foot under the wheelchair. The investigation documented that the facility employee assigned to Resident #73 did not notice the resident was care planned for a calf support and that employee reported that there was not a calf support in Resident #73's room the day of the incident. The investigation documented that the incident was a care plan violation. During an interview on 8/23/24 at 4:13 PM, Certified Nurse Aide #3 stated they were the staff member assigned to Resident #73 on 8/1/23 when the resident sustained an injury to their toe. Certified Nursing Assistant #3 stated when they got Resident #73 out of bed and placed them into their wheelchair, the wheelchair did not have a calf board. They stated they applied blue booties to Resident #73's feet. They stated at the time of the incident they were not aware that Resident #73 was to have a calf board in place and would have had they read Resident #73's care plan posted on their bathroom door prior to getting them out of bed. During an interview on 8/26/24 at 8:12 AM, the Director of Rehab Services stated they completed a wheelchair evaluation on Resident #73 on 8/2/23 due to an incident report on 8/1/23. The Director of Therapy stated that at the time of the incident Resident #73's wheelchair did not have on calf board as planned. They stated the purpose of Resident #73's calf board was to prevent their feet from falling off their wheelchair pedals. The Director of Therapy stated they expected staff to read the care plan prior to the start of care. During a telephone interview on 8/26/24 at 9:47 AM, Licensed Practical Nurse #6 stated that Resident #73 was in their wheelchair wheeling themselves down the hallway and they noted a trail of blood on the carpet. Licensed Practical Nurse #6 stated that Resident #73 did not have the calf board in place and their foot fell off the wheelchair pedal. They stated the calf board lays across both foot pedals to prevent the feet from falling in-between the pedals. Licensed Practical Nurse #6 stated they were not sure why the calf board was not in place. Licensed Practical Nurse #6 stated staff were to read a resident's care plan when they are assigned to a resident. During an interview on 8/26/24 at 11:37 AM, Registered Nurse #7 Team Leader of the unit stated on 8/1/23 it appeared that Resident #73 ran over their own right foot while in the wheelchair and there was a lot of active bleeding. Registered Nurse #7 stated that Resident #73 did not have their planned foot board in place at the time of the incident and if it was, the injury would have been prevented. Registered Nurse #7 stated they would have expected Certified Nurse Aide #3 to read Resident #73 closet care plan and alert the nurse if their specialty equipment was not in their room. Registered Nurse #7 stated that Certified Nursing Assistant #3 should have not gotten Resident #73 out of bed until they had the proper equipment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024

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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/24 at 12:25 PM, the Director of Nursing stated upon investigation of Resident #73's incident on 8/1/23, Certified Nursing Assistant #3 did not implement the residents care planned calf board. The Director of Nursing stated they did not know why the calf board was not in place but that they would expect the staff to review the closet care plan prior to care. The Director of Nursing stated it was important for staff to follow a resident care plan and ensure devices were in place to avoid any injury. 10 NYCRR 415.12(h)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on interview, and record review conducted a Compliant investigation (Complaint # NY00339904) during the Standard survey completed on 8/26/24, the facility and pharmacy services did not effectively implement processes to acquire, dispense and administer medications to meet the needs of each resident. Specifically, one (Resident #260) of four residents reviewed for controlled substances was not administered a regularly scheduled controlled antiseizure medication as ordered and missed a total of 5 doses. Subsequently, the resident experienced seizure activity was transferred to the hospital. Additionally, facility staff did not notify the provider of the unavailability of the medication, and the pharmacy provider did not notify the medical provider that only a 14-day supply of the mediation was dispensed versus the 30-day as ordered. The finding is: The policy titled Controlled Substances with an effective date of 9/2021 documented an official NYS (New York State) triplicate script must state the number of tabs or the number of days and number of refills. The 11:00 PM -7:00 AM shift nurse will check all controlled substances for needed re-fills weekly. Any controlled substances with less than one week supply will be placed on the Controlled Substance Re-Order Form. The 11:00 PM -7:00 AM shift supervisor will collect the forms and bring them to the Nursing Administration Office. The Assistant Director of Nursing (ADON)/designee will give them to the prescriber so that prescriptions will be written. The prescriber will bring the prescriptions to the Nursing Supervisor who will make copies of the controlled substance prescriptions and will enter in the Nursing Supervisor Logbook. The pharmacy courier will pick up the signed prescriptions from the Nursing Supervisor with the next controlled substance delivery. The policy titled Physician Services and Philosophy with an effective date of 8/2019, documented the licensed nursing staff notifies the Attending Physician/Nurse Practitioner/Physician Assistant for required, issuance/review of medical orders; when emergency orders are necessary, or if the plan of care is creating adverse reactions. A Licensed Nurse records notification of the Physician/Nurse Practitioner/Physician Assistant in the resident's medical record. The policy titled Medication and Treatment Administration Record with an effective date of 7/2023 documented the facilities purpose is to assure accurate administration of medications and treatments. The policy titled Medication Ordering, Credits and Delivery of Prescription Medication and Treatments with an effective date of 9/2021 documented the purpose is to ensure that orders for prescription medications are faxed or sent to the Vendor Pharmacy and the prescribed medications are obtained and administered in a timely manner. If the medication is not available from the pharmacy but the time the next scheduled dose, the nurse must contact the Nursing Supervisor to review if the medication can be obtained from the Emergency Box. If the medication cannot be obtained from the Emergency Box and is not available from the Vendor Pharmacy, the nurse will contact the Medical Team for orders. Additionally, each nurse passing medication daily is responsible for the reordering of prescriptions medications. The nurse must be aware of the remaining doses when punching out the doses to be administered. The EMAR (electronic medical record) will indicate if the reorder is accepted or if it is too soon to order. The system will also indicate If medication has already been re-ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #260 had diagnoses that included cerebral infarction (stroke), epilepsy (seizure disorder), and metabolic encephalopathy (chemical imbalance in the blood that effects the brain). The Minimum Data Set (a resident assessment tool) dated 3/28/24 documented Resident #260 was severely cognitively impaired, usually understands and was sometimes understood. Review of facility submitted Investigation 5 Day Report, dated 4/29/24 at 4:17 PM, documented Resident #260 had active seizure activity on 4/22/24 at 8:40 AM causing them to be sent to the emergency room for further evaluation and treatment. Facility Investigation documented Resident #260 ran out of seizure medication awaiting it to arrive from pharmacy. The medication, Briviact (controlled antiseizure medication), was ordered through the electronic medication administration record on 4/16/24. The provider received the renewal order that was placed on 4/16/24 but did not renew the prescription due to ordering 60 tablets of this medication on 4/2/24. On 4/3/24, pharmacy sent a 14-day supply (28 tablets) due to insurance stipulations. On 4/19/24, Resident #260 was completely out of their seizure medication. The active physician's orders dated 12/19/23 documented Resident #260 was to receive Briviact 50 milligrams (mg) 1 tab twice daily. Review of electronic pharmacy receipt provided by the Director of Nursing documented Resident #260's Briviact was for a 30-day supply (28 tablets), and on 4/3/24 a 14-day supply (28 tablets) was sent. Review of medication administration record dated 4/19/24 through 4/21/24 revealed over a period of 2.5 days a total of 5 doses of Briviact were not administered as ordered by the medical provider due to its unavailability. Review of 24 Hour Interdisciplinary Report dated 4/19/25, 4/20/24, and 4/21/24 revealed there was no evidence that Resident #260 was added to the report sheet regarding the unavailability of the Briviact, to monitor for seizure activity or that the provider and pharmacy were notified. The 24- Hour Interdisciplinary Report dated 4/22/24 documented Resident #260 was sent out to emergency room for seizure activity at 9:20 AM. The resident returned from the hospital on the 3:00 PM to 11:00 PM shift with an order to continue taking Briviact 50 milligrams by mouth twice a day. Review of the Nursing progress note dated 4/22/24 at 12:08 PM, Registered Nurse #1 documented at 8:40 AM Resident #260 was being provided hands on care when they started to have emesis described as clear mucous and became sweaty. This writer entered the room and Resident #260 appeared to be actively seizing, the resident's body stiffened, started convulsing, and resident was unresponsive to name. This lasted for approximately 90 seconds. Resident #260 started to return to baseline, and the provider was contacted, per provider no Ativan (medication that acts on the brain and nerves to produce a calming effect that relieves symptoms of anxiety) was needed because Resident #260 was returning to baseline. Resident #260 then appeared to be in distress, was no longer responsive and began to tremor. The provider was contacted again, and an order was given to send Resident #260 out to emergency room for evaluation. Emergency medical services were contacted, and upon arrival administered an injection. Resident #260 was transferred by ambulance to the emergency room for evaluation. Upon retrieving residents' packet to be sent out, a review of medication administration record showed Resident #260 had missed 5 doses of seizure medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Physician progress note dated 4/23/24, Physician Assistant #1 documented Resident #260 sent to emergency department yesterday for breakthrough seizure activity. On review patient reportedly had not received their Briviact since April 19th, 2024. On review of (mobile prescription software), a 30-day supply (60 tabs) was on April 3rd with anticipated coverage through 5/3/24. Investigation unearthed that pharmacy had sent over a 14-day supply due to medication being a brand name. This had not been reported to me previously. Does not appear that a call out was placed to notify provider (myself) or supervising physician of this discrepancy or to notify that their final doses had been utilized. During an interview on 8/23/24 at 8:32 AM, Licensed Practical Nurse #1 stated they worked the 7:00 AM to 3:00 PM shift on 4/19/24 and administered the last dose of Briviact to Resident #260. Licensed Practical Nurse #1 stated the medication was written on the re-order form on Tuesday 4/16/24 so they were expecting it to come from pharmacy. Licensed Practical Nurse #1 stated they called pharmacy and pharmacy stated it was an insurance and provider issue. They reported this to the team leader, Registered Nurse #1 and It was out of their hands now. Licensed Practical Nurse #1 stated they returned to work on Saturday 4/20/24, and the medication still had not been delivered. The overnight staff said, it was being handled, the doctor had said something I think. Licensed Practical Nurse #1 stated they assumed the doctor did what they needed to do, and that pharmacy was sending the medication. Licensed Practical Nurse #1 stated Resident #260 was stable throughout the weekend and had no changes in their vital signs. Licensed Practical Nurse #1 stated there was a communication issue that led to Resident #260 not receiving it as ordered. Licensed Practical Nurse #1 stated any nurse can put a call out to the provider regarding medication. During a telephone interview on 8/23/24 at 9:51 AM, Registered Nurse #1 Team Leader stated they were never made aware prior to Resident #260 having a seizure that they were out of Briviact. Registered Nurse #1 stated it was the nurse passing the medication who was responsible for contacting the pharmacy and/or the provider if it was unavailable. If the Licensed Practical Nurses were unable to get a hold of the provider, then they should report it to the Nursing Supervisor. During a telephone interview on 8/23/24 at 10:21 AM, Pharmacy Consultant stated Briviact was a brand name medication and only sent in a 14-day supply. The physician would have to write a script and between nursing and pharmacy, they would communicate and get refills. During a telephone interview on 8/23/24 at 10:45 AM, the Medical Director stated the procedure for when a medication was unavailable in the facility the nurse should notify the provider and then the provider will respond with a new order, a substitution in the interim, or tell them to call the pharmacy. If it was an insurance issue, there was a team that deals specifically with that. The provider cannot give an order if they were not aware the medication was unavailable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 8/23/24 at 10:58 AM, Physician Assistant #1 stated if a medication was a controlled substance or as needed, they were sent in 14-day supplies. The nurse will send a notification and the provider will determine if the order was okay to be renewed. Sometimes controlled substances were sent in a 14-day supply for insurance reasons. This is something pharmacy needs to articulate to them so that the providers can refill appropriately. Physician Assistant #1 stated the nurse were responsible for determining the count for controlled substances and should reach out and let the provider know when a refill was needed. Physician Assistant #1 stated they most definitely expect to be updated when a resident is out of a controlled substance, especially one like Briviact. In the incident with Resident #260, there was a miscommunication issue. Physician Assistant #1 stated if they would have been made aware Resident #260 hadn't received their seizure medication, they would have put an order in themselves and had pharmacy send it over urgently and would have had Ativan on board in case they developed a seizure in the interim. During a telephone interview on 8/23/24 at 11:08 AM, the Pharmacist stated Briviact was a brand name medication. Since the original order date of 12/19/23, Briviact had been sent in a 14-day supply for Resident #260. Pharmacist stated a prescription was written on 4/3/24 for a 30-day supply but the system only allowed a 14-day supply to be provided. The Pharmacist stated there were no notes indicating the facility attempted to call and no refill requests were received between 4/2/24 and 4/22/24. The Pharmacist stated usually a 30-day prescription will be written and then they provider will replenish the prescription every 14 days. The facility will usually call or send a refill sheet when a refill was needed. The Pharmacist stated there were no alerts to the provider from the pharmacy to let them know a 14-day supply was sent instead of a 30-day supply that was ordered. During a telephone interview on 8/23/24 at 11:41 AM, Registered Nurse #2 stated they worked the 3:00 PM to 11:00 PM shift on April 20th and 21st, 2024. When they received report from the 7:00 AM to 3:00 PM shift on April 20th, they were told the medication Briviact was unavailable in the facility. Registered Nurse #2 stated Licensed Practical Nurse #1 told them they had called pharmacy, and the medication was on its way. When it did not arrive on the run that night, Registered Nurse #2 stated they called pharmacy and was told it was on its way. Registered Nurse #2 stated they wrote on the report sheet that they were waiting for the medication. Registered Nurse #2 stated they came in Monday, April 22nd, and was informed Resident #260 had a seizure and was sent out to the hospital because their seizure medication never came. Registered Nurse #2 stated they should not have taken the day shift nurse word for it and should have called the provider themselves. During a telephone interview on 8/23/24 at 3:35 PM, Registered Nurse #4 Nursing Supervisor stated they were the supervisor on Sunday 4/21/24 from 7:00 AM to 11:00 PM and was not made aware that Resident #260 was out of their seizure medication. Registered Nurse #4 stated if they were made aware then they would have notified the on-call provider and got an order right away. Registered Nurse #4 stated they should have been made aware that the medication was unavailable. During a telephone interview on 8/23/24 at 4:00 PM, Registered Nurse #5 Nursing Supervisor stated they were the supervisor on Saturday 4/20/24 from 3:00 PM to 11:00 PM. Registered Nurse #5 stated they were never made aware that Resident #260 was out of their seizure medication. Registered Nurse #5 stated they should have been aware that the seizure medication was not available. Registered Nurse #5 stated that if they were made aware they would have contacted the on-call provider and sent out an urgent notification to them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/26/24 at 10:29 AM, the Director of Nursing stated they were aware Resident #260 had missed a few doses of their seizure medication which resulted in Resident #260 having a seizure and being sent out to the hospital. The Director of Nursing stated the process for when a medication was not available in the facility was to call pharmacy. The Director of Nursing stated they expect staff to report off to the next shift if a medication was not available and have them follow up with pharmacy. If pharmacy cannot give a reason, notify the Nursing Supervisor who would make a call to the provider for further guidance. During an interview on 8/26/23 at 10:52 AM, Licensed Practical Nurse #3 stated they worked Monday 4/22/24 7:00 AM to 3:00 PM and was Resident #260's nurse. Licensed Practical Nurse #3 stated that morning the Certified Nurse Aide alerted to them, and Registered Nurse #1, that Resident #260 wasn't quite themselves. Registered Nurse #1 went in to Resident #260's room to assess them. Licensed Practical Nurse #3 stated when they entered the room, Resident #260 wasn't talking and was not at their baseline. Resident #260 was then sent out to the hospital. Based on the following corrective actions it was determined the facility implemented corrective actions to correct the non-compliance prior to the start of survey teams' entrance to the facility on [DATE] at 8:30 AM: -On 4/23/24 a Special Quality Assurance Performance Improvement meeting was held to determine the root cause and to put a prevention plan into place. - Director of Nursing completed a facility wide audit on all controlled medications being readily available to the residents. - Briviact was added to the facilities emergency Pyxis system (automated dispensing system) - Policies and Procedures were reviewed and revised - As of 6/21/24 facility wide nurse education was completed along with facility wide competency quizzes, and specific staff counseling completed. During the Standard survey completed on 8/26/24 it was verified through observations, staff interviews and record review the facility implemented their plan, re-educated their nursing staff on the process for notifications to pharmacy and providers, acquiring medications, process for medications that maybe unavailable. NYRCC 415.18 (a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on observation, interview, and record review conducted during a Compliant investigation (Complaint # NY00339904) during the Standard survey completed on 8/26/24 the facility did not ensure that its residents were free of significant medication errors for one (Resident #260) of three residents reviewed for anti-seizure medications. Specifically, Resident #260 was not administered 5 doses of their anti-seizure medication. This resulted in a significant medication error for Resident #260. The resident had seizure activity and was transferred hospital for evaluation and treatment. The finding is: Refer to F 755 Pharmacy Services/procedures, scope and severity F. The facility policy titled Medication and Treatment Administration Record with an effective date of 7/2023 documented the purpose is to assure accurate administration of medication and treatments. The policy titled Physician Services and Philosophy with an effective date of 8/2019, documented the licensed nursing staff notifies the Attending Physician/Nurse Practitioner/Physician Assistant for required, issuance/review of medical orders; when emergency orders are necessary, or if the plan of care is creating adverse reactions. A Licensed Nurse records notification of the Physician/Nurse Practitioner/Physician Assistant in the resident's medical record. Resident #260 had diagnoses that included cerebral infarction (stroke), epilepsy (seizure disorder), and metabolic encephalopathy (chemical imbalance in the blood that affects the brain). The Minimum Data Set (a resident assessment Tool) dated 3/28/24 documented Resident #260 was severely cognitively impaired, usually understands and was sometimes understood. The active physician's orders dated 12/19/23 documented Resident #260 was to receive Briviact (controlled anti-seizure medication) 50 milligrams (mg) 1 tab twice daily. Resident #260's medication, treatment, and task administration record report for April 2024 documented that Briviact 50 milligrams was not administered as ordered and scheduled on 4/19/24 at 4:03 PM, 4/20/24 at 9:04 AM, 4/20/24 at 4:54 PM, 4/21/24 at 9:43 and on 4/21/24 at 4:28 PM because the medication was unavailable. Review of 24-Hour Interdisciplinary Report dated 4/22/24 documented Resident #260 was sent out to emergency room for seizure activity at 9:20 AM. Review of Nursing progress note dated 4/22/24 at 12:08 PM, Registered Nurse #1 documented at 8:40 AM Resident #260 was being provided hands on care when they started to have emesis described as clear mucous and became sweaty. This writer entered the room and Resident #260 appeared to be actively seizing, residents body stiffened, started convulsing, and resident was unresponsive to name. This lasted for approximately 90 seconds. Resident #260 started to return to baseline, and the provider was contacted, per provider no Ativan was needed because Resident #260 was returning to baseline. Approximately 2 minutes later Resident #260 then appeared to be in distress, was no longer responsive and began to tremor. The Physican was again contacted with an order given to send tote hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician progress note dated 4/23/24, Physician Assistant #1 documented Resident #260 was sent to emergency department yesterday for breakthrough seizure activity. On review, the resident reportedly had not received their Briviact since April 19th, 2024. They received 10 mg Versed (antiseizure medication) during transportation via emergency medical services. On initial evaluation they were responsive to painful stimuli only. They had 1 gram of Keppra (antiseizure medication) and 1 liter of fluids intravenously. Review of facility submitted Investigation 5 Day Report, dated 4/29/24 at 4:17 PM, documented Resident #260 had active seizure activity on 4/22/24 at 8:40 AM causing them to be sent to the emergency room for further evaluation and treatment. On 4/19/24, Resident #260 was completely out of their seizure medication. During an interview on 8/23/24 at 8:32 AM, Licensed Practical Nurse #1 stated they worked the 7-3 shift on 4/19/24 and administered the last dose of Briviact to Resident #260. Licensed Practical Nurse #1 stated the medication was written on the re-order form on Tuesday 4/16/24 so they were expecting it to come from pharmacy. They called pharmacy on 4/19/24 and pharmacy stated it was an insurance and provider issue. They reported this to the team leader, Registered Nurse #1. It was out of their hands now. Licensed Practical Nurse #1 stated they returned to work on Saturday 4/20/24, and the medication still had not been delivered. The overnight staff said, it was being handled, the doctor had said something I think. Licensed Practical Nurse #1 stated they assumed the doctor did what they needed to do, and that pharmacy was sending the medication. Licensed Practical Nurse #1 stated Resident #260 was stable throughout the weekend and had no changes in their vital signs. Licensed Practical Nurse #1 stated Briviact was an important medication and there was a communication issue that led to Resident #260 not receiving it as ordered. During a telephone interview on 8/23/24 at 9:51 AM, Registered Nurse #1 stated they were never made aware prior to Resident #260 having a seizure that they were out of the medication. Registered Nurse #1 stated Briviact was an important medication and Resident #260 was at risk for having a seizure if they missed any doses. During a telephone interview on 8/23/24 at 10:21 AM, Pharmacy Consultant stated if a resident had epilepsy and missed a few doses of the medication it would not be ideal, they could have refractory seizures. Pharmacy Consultant stated it was not ideal for seizure medications to abruptly stop and Resident #260 missing 5 doses of their Briviact put them at risk for having a seizure. Even if someone has never had a seizure and was on a seizure medication and missed doses, they could have a rebound seizure. During a telephone interview on 8/23/24 at 10:45 AM, Medical Director stated a seizure medication was one that was important and should be given as ordered. Missed doses of a seizure medication puts any person at risk for having seizures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024

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 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a telephone interview on 8/23/24 at 10:58 AM, Physician Assistant #1 stated Briviact was an important medication and without it a person was at risk for break through seizures. Physician Assistant #1 stated they would expect to be updated if a resident missed a dose of their seizure medication as soon as possible. Any more than 2 days maximum without receiving the seizure medication would be too far. In the incident with Resident #260, there was a miscommunication issue. Physician Assistant #1 stated Resident #260 experienced a seizure from missing doses of their seizure medication and was sent out to the hospital appropriately. Physician Assistant #1 stated because Resident #260 had a history of stroke and seizure disorder, missing doses of their seizure medication could be potentially harmful, but not life threatening.

During a telephone interview on 8/23/24 at 11:08 AM, the Pharmacist stated the half-life (how long a drug remains in the blood) of Briviact for people 65 and younger was 9.0 hours. If someone were to miss 5 doses of their Briviact they were at risk for a partial onset seizure. If someone was on a seizure medication and missed any dose they were at risk for seizures. They're in the possibility of having a seizure, whether they have had one or not.

During a telephone interview on 8/23/24 at 11:41 AM, Registered Nurse #2 stated they worked the 3:00 PM-11:00 PM shift on April 20th and 21st, 2024. When they received report from the 7-3 shift on April 20th, they were told the medication Briviact was unavailable in the facility. Registered Nurse #2 stated Licensed Practical Nurse #1 told them they had called pharmacy, and the medication was on its way. Registered Nurse #2 stated they should not have taken the day shift nurse word for it and should have called the provider themselves. Registered Nurse #2 stated Resident #260 was at risk for having seizures without the medication.

During a telephone interview on 8/23/24 at 3:35 PM, Registered Nurse #4 stated they were the nursing supervisor on Sunday 4/21/24 from 7:00 AM to 11:00 PM and they should have been made aware that the medication was unavailable. Registered Nurse # stated a seizure medication is very important and puts the resident at risk for having a seizure if they miss a dose.

During a telephone interview on 8/23/24 at 4:00 PM, Registered Nurse #5 stated they were the nursing supervisor on Saturday 4/20/24 from 3:00 to 11:00 PM. Registered Nurse #5 stated they were never made aware that Resident #260 was out of their seizure medication and should have been. Registered Nurse #5 stated a seizure medication was very important and puts that person at risk for having a seizure if they miss a dose.

During an interview on 8/26/24 at 10:29 AM, the Director of Nursing stated they were aware Resident #260 had missed a few doses of their seizure medication and that resulted in Resident #260 having a seizure and being sent out to the hospital. The Director of Nursing stated even one dose of a seizure medication was too many to miss, it puts the patient at risk for having a seizure.

Based on the following corrective actions it was determined the facility implemented corrective actions to correct the non-compliance prior to the start of survey teams' entrance to the facility on [DATE] at 8:30 AM:

-On 4/23/24 a Special Quality Assurance Performance Improvement meeting was held to determine the root cause and to put a prevention plan into place.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Director of Nursing completed a facility wide audit on all controlled medications being readily available to the residents. - Briviact was added to the facilities emergency Pyxis system (automated dispensing system) - Policies and Procedures were reviewed and revised - As of 6/21/24 facility wide nurse education was completed along with facility wide competency quizzes, and specific staff counseling completed. During the Standard survey completed on 8/26/24 it was verified through observations, staff interviews and record review the facility implemented their plan, re-educated their nursing staff on the process for notifications to pharmacy and providers, acquiring medications, process for medications that maybe unavailable. NYRCC 415. 12 (m)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on observation, interview, and record review conducted during a Standard survey completed on 8/26/24, it was determined the facility did not ensure residents received routine dental services to meet the needs of each resident for two (Residents #10, #112) of three residents reviewed. Specifically, Resident #10 had been missing dentures since 10/28/20 and was not provided with timely follow up appointments for denture replacement. There were no dental consults completed after 10/20 through 08/24. Additionally, Resident #112 had a delay in receiving routine dental services on admission, there was no physician order for dental consults and had not received a dental consult until 1/3/24. The findings are: The policy and procedure titled Dental Services dated 8/2021 documented that it was the responsibility of nursing staff, vendor dental services and the medical team to coordinate dental care for residents. All residents are referred to the Dental Clinic and seen within 30 days of admission. Recommendations for dental care and follow up are documented in the Vendor Dental Service's electronic medical record. A paper copy of this documentation will be kept in the resident's paper medical record. 1. Resident #10 had diagnoses that included cerebral palsy (condition that affects movements and posture), epilepsy (seizure disorder), and neuromuscular dysfunction of bladder (nerves and muscles of urinary system don't work together causing urinary tract dysfunction). The Minimum Data Set (a resident assessment tool) dated 6/12/24 documented Resident #10 was cognitively intact, was understood and understands. The assessment documented the resident was edentulous (without teeth). The Minimum Data Set Care Area assessment dated [DATE] had a note which documented Resident #10 was noted as edentulous but had full upper and lower dentures. Dental consult per policy and as needed. The comprehensive care plan dated 4/28/23 (current) documented Resident #10 required supervision with oral hygiene, removing/placing dentures in mouth, and managing denture soaking and rinsing. Additionally, the comprehensive care plan documented Resident #10 was on a modified diet of soft consistency food due to dysphagia (difficulty swallowing). The closet care plan (a guide used by staff to provide care) dated 8/22/24 documented Resident #10 had no dental appliances. The active physician's order dated 10/16/17 documented Resident #10 was to have a dental consult as needed. The dental consult note dated 10/28/20 documented Resident #10 was seen for a periodic oral exam. Resident had lost complete maxillary (upper) denture and had not worn mandibular (lower) complete denture. Primary impressions were to be taken at next visit. Review of the schedule list of residents to be seen by the onsite dentist from 11/9/22 to 7/17/24, provided by the Administrative Control Clerk Supervisor on 8/26/23 at 10:30 AM, revealed Resident #10 was not seen by the dentist between those dates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/23/24 at 8:47 AM, Resident #10 was sitting up in their bed with no dentures present. Resident #10 stated they have issues with chewing and were unable to eat properly due to missing dentures. Resident #10 stated they had a pair of dentures (uppers/lowers) when they arrived at the facility, but the dentures were lost at some point. Resident #10 stated they had seen the dentist and had a sore in their mouth, so impressions were not taken at that visit, and they were supposed to follow up but has not yet. During a telephone interview on 8/23/24 at 10:08 AM, Registered Nurse #1 stated Resident #10 had dentures at one point but could not remember when they were lost. Registered Nurse #1 stated Administrative Control Clerks were responsible for scheduling appointments and follow ups. Registered Nurse #1 stated there was an in-house dentist and residents go on a list to be seen by the dentist when needed. During an interview on 8/23/24 at 12:12 PM, the Administrative Control Clerk Supervisor reviewed Resident #10's electronic medical record and was unable to find any dental consults. Administrative Control Clerk Supervisor stated they were going to look for Resident #10's dental consults. During a telephone interview on 8/26/24 at 9:16 AM, the Director of Ambulatory Services for the Dental Clinic stated Resident #10 was last seen by the dentist on 10/28/20. The Director of Ambulatory Services for the Dental Clinic stated there were not any dental consults for Resident #10 after 10/28/20. During an interview on 8/26/24 at 9:24 AM, the Administrative Control Clerk Supervisor stated Resident #10's chart may have been thinned and they would check in medical records for any more dental consults. Administrative Control Clerk Supervisor returned and stated they were unable to locate any dental consults for Resident #10 after 10/28/20. During an interview on 8/26/24 at 10:30 AM, the Administrative Control Clerk Supervisor stated that on admission the nurses would be responsible for obtaining an order for dental consults and would then enter the order in the electronic medical record. The Administrative Control Clerk Supervisor stated that once the order was placed in the electronic medical record it would automatically print to their office and they would be responsible to schedule residents on the dental list to be seen. During an interview on 8/26/24 at 10:36 AM, the Director of Nursing reviewed the dental policy and stated all residents should be seen upon admission and annually by the dentist. The Director of Nursing stated they expected Team Leaders and Administrative Control Clerks to work together and make sure all residents were being seen by the dentist appropriately. Nursing staff should follow up and contact the dentist as needed. The Director of Nursing stated Resident #10 should be seen immediately by the dentist due to them not being seen since 2020. It was important for dental hygiene and dignity. 2. Resident #112 was admitted to the facility on [DATE] with diagnoses of dementia, epilepsy (disease that causes seizures), and glaucoma (eye disease that causes vision loss). The Minimum Data Set, dated dated dated [DATE] documented Resident #112 had moderate cognitive impairment was usually understood and usually understands. The assessment documented the resident required partial/moderate assistance (staff provides less than half the effort) from staff for oral hygiene. Additionally, review of Resident #112's Minimum Data Set, dated dated dated [DATE] revealed that Resident #112 was edentulous, at risk of altered nutritional status related to missing teeth and did not wear dentures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER: Terrace View Long Term Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan with a last review date 2/27/24 and identified as active documented dental care with interventions that included nursing to provide/encourage oral hygiene and assess condition of oral cavity. There was no documented evidence resident had dental services as needed. Review of the closet care plan dated 6/13/24 documented Resident #112 had no dental appliances, required minimum assistance with oral care, and received a regular consistency diet. The electronic and paper medical record for Resident #112 dated 11/8/22 through 8/22/24 documented they had been seen by the dental clinic for a comprehensive oral exam on 1/3/24. There was no evidence of any prior dental evaluations documented in the medical record, and no evidence Resident #112 refused dental consults. Review of Resident #112's physician orders from 11/8/22 through 8/22/24 revealed there was no physician order in place for dental consults. Additionally, the electronic and paper medical record lacked dental consents, declinations, and/or refusals for dental services. Review of the schedule list of residents to be seen by the onsite dentist from 11/9/22 to 12/27/23 provided by the Administrative Control Clerk Supervisor on 8/26/24 at 10:30 AM, revealed that Resident #112 was not seen for an admission dental consult. During an interview on 8/21/24 at 9:36 AM, Resident #112 stated they had some difficulty chewing certain foods and was not aware if they were on a special diet. Resident #112 stated they had dentures at home and would like to have them at the facility. During a telephone interview on 8/26/24 at 9:16 AM, the Director of Ambulatory Services for the Dental Clinic stated that Resident #112 had not been seen in 2022 or 2023 for a routine dental exam. They stated if a resident had refused, refusals would be documented in their medical record under dental consults. During an interview on 8/26/24 at 10:30 AM, the Administrative Control Clerk Supervisor reviewed Resident #112's electronic medical record and stated that Resident #112 did not have a dental consult order upon admission and did not have a dental consult order in place when the resident was seen and should have. During an interview on 8/26/24 at 10:45 AM, Registered Nurse #8 stated that on admission dental consults were a part of the ancillary orders and would be entered into the electronic medical record. They stated the registered nurse or nurse completing the admission would be responsible for entering those ancillary orders. Registered Nurse #8 stated that the Administrative Control Clerks would be responsible for scheduling dental visits. Registered Nurse #8 stated there should be a physician's order for dental consults. During an interview on 8/26/24 at 12:00 PM, the Assistant Director of Nursing #1 stated they were unaware of the process for obtaining dental consents and declinations. They were not aware of any resident dental care concerns and was unsure if there should be a physician order for dental consults. (continued on next page)

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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	08/26/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/26/24 at 12:03 PM, the Operations Manager stated an order for dental consults were part of the standing admission orders that the providers would sign. They stated that all residents would be scheduled to be seen by dentist for admission, annually, and for any concerns. They stated that resident refusals should be documented in the medical record. During an interview on 8/26/24 at 12:35 AM, the Director of Nursing stated Resident #112 should have been seen by the dentist within 30 days of admission and annually. The Director of Nursing stated that dental consults were part of the batch orders entered on admission by the nurses. Resident #112 should have had a physician order for dental consult on admission and for the dental consult received on 1/3/24. NYCRR10 415.17 (c)