STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Hill Nursing Facility, L L C	2699 Wehrle Drive 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interviews, and record reviews conducted during the survey, the facility failed to ensure that each resident was treated with respect and dignity, cared for in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality for one (1) (Resident #111) of five (5) residents reviewed for dignity. Specifically, two (2) staff members were in Resident #11's room on their personal cell phones, while the resident was calling out for assistance versus engaging with and assisting the resident.The findings include:The policy and procedure titled Personal Cell Phone/Electronic Device Use dated 08/22/2023 documented the use of a personal cell phone and other electronic devices while at work may present a hazard or distraction to the user and/or co-employees. The policy documented all personal cell phones were required to be completely turned off while at work. Employees may use personal cell phones only during lunch in designated areas in the facility. The policy added for emergency use; employees should notify their immediate supervisor.The policy and procedure titled Dignity, Respect and Privacy in Treatment and Care date 10/2023 documented the resident has a right to be treated with dignity, respect, privacy and security. The policy documented that Dignity means that in their interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth.Resident #111 had diagnoses that included cognitive communication deficit, heart failure, and chronic obstructive pulmonary disease (chronic lung disease). The Minimum Data Set (a resident assessment tool) dated 03/16/2026 documented the resident had moderate cognitive impairment, understands and was understood by others.The comprehensive care plan dated 03/26/2026 documented that Resident #111 had a potential for alteration in psychosocial well-being/mood related to medical condition, adjustment to subacute rehabilitation and confusion at times. Interventions included to respect and listen to expression of feelings and establish trust.The Kardex Report (a guide used by staff to provide care) dated 04/20/2026 documented Resident #111 was the minimal assistance of one staff member for activities of daily living. The Kardex documented for Resident #111's leisure time activities were to provide 1:1 visits, and transport them to and from activities as desired. During an observation on 04/17/2026 at 11:25 AM, Resident #111 was in their room sitting in their wheelchair yelling out for assistance. Resident Assistant #1 was standing about three feet away from Resident #111, facing the window with their back turned partially away, they had their cellular phone in their hand taping the screen with their finger as if they were texting. At this time, Resident Assistant #1 stated that they could not find Resident #111's certified nurse aide. Resident Assistant #2 was also in the room sitting in a recliner chair behind Resident #111, and the residents back was to Resident Assistant #2. Resident Assistant #2 also had their cellular phone in their hand, and the screen was lit up.During an interview on 04/17/2026 at 11:35 AM, Resident Aide #1 stated they were assigned to Resident #111 to keep them company and busy in attempts to lower the resident's anxiety. Resident Aide #1 stated they were on their cellular device because they were receiving a call from their own family member that was important and personal. They stated the facility policy was that staff were not supposed to have their phones on them because it can cause the staff members to comminute with others on the phone (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: 335757	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2026
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instead of keeping their attention on the residents. Resident Aide #1 stated it was disrespectful to be on their phone in front of a resident.During an interview on 04/17/2026 at 11:40 AM, Resident Assistant #2 stated they were assigned to keep Resident #111 entertained because the resident did not like to be alone. Resident Assistant #2 stated that they were sitting in Resident #111's recliner behind the resident and they did have their personal phone on because they were shutting off an alarm that was ringing on their phone. Resident Assistant #2 stated they were educated on personal cell phone use, and that staff could keep their phones with them when they were working but the facility did recommend staff keep them in their lockers. Resident Assistant #2 stated staff should not be on their phones in front of residents because it was disrespectful, it was a distraction while working.During an interview on 04/17/2026 at 1:44 PM, Licensed Practical Nurse #9 stated they had asked Resident Assistant #1 and #2 to sit with Resident #111 because the resident tended to have behaviors. Licensed Practical Nurse #9 stated that Resident Assistant #2 should not have been sitting in a recliner behind Resident #111 and both Resident Assistant #1 and Resident Assistant #2 should have been engaging with Resident #111. Licensed Practical Nurse #9 stated that neither resident assistants should have been using their personal cellular phones. They stated that personal cellular phone use should not be used in resident care areas and should be used discreetly elsewhere. Licensed Practical Nurse #9 stated personal cellular phone use in resident care areas was a dignity issue, and it was just rude.During an interview on 04/21/2026 at 10:15 AM, Social Worker #2 stated Resident Assistant #1 and #2 should have been engaging with the resident, especially if the resident was calling out for assistance. Social Worker #2 stated staff should not be using their personal cellular phones in resident care areas because it was a dignity issue toward the residents and personal matters should not be conducted in front of the residents.During an interview on 04/21/2026 at 11:40 AM, the Director of Nursing stated staff were not use their personal cell phones in resident care areas. They stated if staff receive an urgent phone call, then the call should be taken in another area away from the residents. The Director of Nursing stated that Resident Assistant #1 and Resident Assistant #2 should have been giving their attention to Resident #111.During an interview on 04/21/2026 at 11:59 AM, the Administrator stated facility staff should not be using their personal cellular phones in resident care area and the facility takes that situation very seriously. The Administrator stated when staff were on their personal cellular phones in front of residents in resident care areas it did not create a home-like environment, because staff were guests in the residents' environment and the staff work where the residents live.10 New York Codes, Rules, and Regulations 415.3 (a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews, and record reviews conducted during the survey, the facility did not ensure that the resident's person-centered care plan was implemented to meet the resident's medical and nursing needs for one (1) (Resident #19) of one (1) resident reviewed for positioning. Specifically, Resident #119 did not to have their foot buddy (a device that is strapped to the calf and foot pedals of a wheelchair to prevent legs/feet from slipping behind or off of the wheelchair pedals) in place as per their care plan.The findings include:The policy and procedure titled Interdisciplinary Care Planning dated 09/2025 documented that a comprehensive care plan and Kardex (guide used by staff to provide care) must always be current and accurately reflect the resident's status. The Care plan/Kardex must always be reviewed by staff prior to initiating resident care.The policy and procedure titled Positioning-Seating Devices dated 07/19/2023 documented cushions, wedges, bolsters and other corrective devices for seating are properly applied after assessment and implementation by the Rehabilitation Department. Special seating and/or positioning needs are described in the comprehensive care plan. The policy documented the procedure for wheelchair positioning was to support feet by placing them on foot pedals or by use of adaptable cushions and positioning devices are placed as described in the comprehensive care plan.Resident #119 had diagnoses of that included, cardiovascular incident (stroke) with hemiplegia (paralysis on one side of the body), and dementia. The Minimum Data Set (a resident assessment tool) dated 04/14/2026 documented Resident #119 was moderately cognitively impaired, usually understood, and usually understands others. The current comprehensive care plan dated 01/28/2026 documented Resident #119 had self-performance deficit related to activity intolerance, limited mobility and limited range of motion. Interventions included to be out of bed to wheelchair and positioning devices out of bed included a foot buddy. The Kardex dated 04/20/2026 documented Resident #119 was dependent on wheelchair mobility and was to have a foot buddy when out of bed in the wheelchair.Review of interdisciplinary progress notes dated 12/04/2025 to 04/19/2026 revealed there was no documented evidence Resident #119 refused and did not tolerate the use of the foot buddy.During observations on 04/14/2026 at 9:51 AM and 3:10 PM; 04/16/2026 at 9:20 AM; 04/17/2026 at 8:41 AM, 9:32 AM and 10:29 AM, Resident #119 was either in the dining room or sitting in front of the community television in their wheelchair without the foot buddy in place on their wheelchair. Resident #119 was noted to position/move both their legs behind the wheelchair foot pedals.During observation on 04/14/2026 at 9:40 AM and 04/17/2026 at 12:18 PM there was a foot buddy observed on the floor next to the resident's nightstand in their room.During an interview on 04/17/2026 at 1:21 PM, Certified Nurse Aide #3 stated they would know what type of adaptive equipment a resident would need by looking at the Kardex that hangs behind a resident's bathroom door or in their closet. Certified Nurse Aide #3 stated they were responsible for Resident #119's care on 04/14/2026 and 04/17/2026. After review of Resident #119's Kardex in the resident's room they stated that Resident #119 was to have a foot buddy applied to the leg rests on their wheelchair. Certified Nurse Aide #3 pointed to the foot buddy that was next to the resident's nightstand. They stated Resident #119 utilized the foot buddy because the resident does not keep their feet on the foot pedals or places their feet behind the foot pedals and tends to cross their legs at their ankles. Certified Nurse Aide #3 stated they must have forgot to apply Resident #119's foot buddy.During an observation and interview on 04/17/2026 at 1:35 PM, Licensed Practical Nurse #4 reviewed Resident #119's Kardex and stated the resident was to utilize a foot buddy to keep the resident's legs from falling through the wheelchair pedals. Resident #119 was in their wheelchair in front of the community television and Licensed Practical Nurse #4 stated the resident did not have their foot buddy in place. During an interview on 04/21/2026 at 9:20 AM, the Director of Therapy stated they reevaluated Resident #119 for the use of the foot buddy on 04/17/2026 per the request of nursing. They stated the foot buddy remained appropriate for the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident to help them keep their feet on the footrest and they would not fall behind the pedals. The Director of Therapy stated they would have expected Resident #119 to have the foot buddy in place and for staff to follow their plan of care.During an interview on 04/21/2026 at 11:46 AM, the Director of Nursing reviewed Resident #119's care plan and stated Resident #119 was planned to have a foot buddy on their wheelchair and would have expected staff to apply it as it was a recommendation from therapy.10 New York Code Rules Regulations 415.11 (c)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the survey, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for three (3) (Residents #8, #32 and #58) of seventeen (17) residents reviewed for quality of care. Specifically, weights were not obtained daily as ordered by the physician (#8), lack of identification and documentation of a bruise (#32) and medications that were left at the bedside for self-administration without a physician's order (#58).The findings include:The policy and procedure titled Weight Monitoring dated 5/2013 documented that a weight record was used to monitor changes in weight on a weekly or monthly basis. Weekly or more frequent weight checks may be indicated for residents with anorexia, dehydration, obesity, edema, significant changes, or certain medication regimens. Weight frequency will be increased as deemed necessary by Nursing, Dietary, or a Physician. Consistent monitoring of weight gain or loss provides guidance for appropriate intervention in conjunction with the dietician.The policy and procedure titled Documentation of Pressure Ulcer and Chronic Wounds revised 6/23 documented a Skin Inspection is completed weekly on shower day. Skin was non-remarkable unless otherwise noted. Skin Inspection Requirements: inspect all skin surfaces (including heels and elbows), in order do a thorough skin inspection, resident must be turned side to side in bed or if able stand for inspection.The policy and procedure titled Self-Administration of Medications revised on 11/23/2021 documented that each resident is given a detailed explanation of the medications that they may self-administer, the reason for the medication, what to expect, and the possible side effects within their cognitive ability to understand The self-administration of medication is monitored by the Team Leader and the nurse is to document on the electronic medication administration record after the self-administered medications, the time and effect of the medication. Continued approval of the self -administration of medication by the resident is dependent on the resident's compliance with physician orders and facility procedures.1.Resident #8 had diagnoses of congestive heart failure (heart cannot pump blood well enough to meet the body's needs), chronic obstructive pulmonary disease (lung disease that makes breathing difficult), respiratory failure, and a history of pulmonary edema (fluid around the lungs). The Minimum Data Set (a resident assessment tool) dated 02/10/2026 documented Resident #8 was cognitively intact, able to understand and be understood by others, had no behavior or rejection of care, and was prescribed diuretics (medication that helps decrease swelling and increase urination).The current comprehensive care Plan dated 02/10/2026 documented to monitor for edema. The resident was at risk for altered nutrition related to congestive heart failure, with interventions including a no added salt diet, daily weights, and reporting weight gains of three (3) pounds in 24 hours or five (5) pounds in seven (7) days. The resident was also at risk for dehydration related to diuretic therapy, and fluid restrictions, with interventions including a 1500 milliliter fluid restriction.The Kardex (a guide used by staff to provide care) dated 04/20/2026 documented a 1500 milliliter fluid restriction and a no added salt diet. The Kardex did not document weight monitoring was needed.Review of a physician's order dated 11/05/2025 and renewed on 02/16/2026 documented Resident #8 was to be weighed daily on day shift, with parameters of a three (3) pound gain in 24 hours or a five (5) pound gain in seven (7) days to update provider.Review of weights in the electronic medical record documented on 02/11/2026 Resident #8 weighed 211.6 pounds and on 02/13/2026 weighed 217.2 pounds, an increase of 5.6 pounds in two (2) days.Review of weights in the electronic medical record documented on 03/11/2026 Resident #8 weighed 211.6 pounds and on 03/14/2026 weighed 217.9 pounds and an increase of 6.3 pounds in three days. There was no documentation evidence the provider was notified.A dietician progress note dated 04/15/2026 documented weights over the past month ranged 208.9-219.4 lbs. Fluid restriction, ace wraps, and Bumex (diuretic) continued per order.Review of daily weights in the treatment administration orders (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for April of 2026 revealed weights were not obtained on 04/04/2026, 04/06/2026, 04/07/2026, 04/08/2026, 04/09/2026, 04/12/2026, 04/13/2026, and on 04/16/2026. There was no documented evidence as to why Resident #8's weight was not obtained on these days and/or the provider was made aware the weights were not obtained.During an interview on 04/17/2026 at 10:38 AM, Certified Nursing Aide #9 stated they did not weigh Resident #8 and had not been told to do so.During an interview on 04/17/2026 at 10:52 AM, Licensed Practical Nurse #10 stated Resident #8 was weighed daily due to congestive heart failure and fluid retention. They stated they were not aware that Resident #8 had not been weighed multiple times in the months of February, March and April. They stated the team leader should have ensured daily weights were completed.During an interview on 04/20/2026 at 9:54 AM, Licensed Practical Nurse #2 Team Leader stated Resident #8 required daily weights due to congestive heart failure. They stated the rationale was to identify fluid overload, exacerbation of congestive heart failure, pleural edema (fluid that accumulates in the lung tissues), and avoidable hospitalization. They stated they were on vacation during the missed weights in April and did not notice they were not completed. They verified 10 days in the treatment administration record for February and 11 days for March that Resident #8 was not weighed as ordered. Additionally, they verified the provider was not notified of parameters ordered for weight monitoring on 02/13/2026 and 03/14/2026 and should have been.During an interview on 04/20/2026 at 10:25 AM, Certified Nursing Aide #1 stated they had not weighed Resident #8. They stated they usually weighed the resident after lunch and would notify the nurse and place the weight in the weight book. They stated they had worked with this resident every day and sometimes would jot their weight down on a scrap piece of paper and give it to the nurse. They stated Resident #8 never refused weights and did not know why daily weights were important.During an interview on 04/20/2026 at 10:29 AM, Licensed Practical Nurse #2 Team Leader stated it was their responsibility to ensure daily weights were completed.During an interview on 04/20/2026 at 11:19 AM, the Registered Dietician stated their role was to monitor weight changes in residents with congestive heart failure. They stated Resident #8 was expected to be weighed daily and missed weights could delay identification of fluid overload. They stated they meet monthly with the provider to review weights, and the provider would decide if orders needed to be adjusted. They were unable to provide a daily log sheet for Resident #8 but provided weekly and monthly weight sheets for Resident #8. They stated if they needed their daily weight they would look in their electronic medical record and print them out. They stated they did review weights daily and thought the weights were missed due to resident refusal.During an interview on 04/20/2026 at 11:47 AM, the Director of Nursing stated all staff should have known Resident #8 required daily weights. They stated there was a system in place for missed orders and nursing managers should have populated a missed medication/treatment report. They stated missed weights could inhibit identification of fluid overload and congestive heart failure exacerbation. They stated staff were expected to follow physician orders, document, follow parameters, and contact the provider as needed. They stated if the weights were not completed daily, for consecutive days of three (3) or more days, they would expect the provider to be notified by the unit manager or the team leader.During an interview on 04/20/2026 at 1:16 PM, Nurse Practitioner #1 stated Resident #8 had multiple comorbidities that required to be carefully monitored, including daily weights, shortness of breath, and swelling. They stated missed weights could impair clinical judgment regarding fluid status and overall medication management but would also rely on other symptoms. They considered Resident #8 at moderate risk for congestive heart failure exacerbation.During an interview on 04/21/2026 at 9:41 AM, the Medical Director stated Resident #8 had been stable but daily weights were an important component to monitor congestive heart failure. They stated they expected staff to monitor weights daily and follow parameters for notifying the physician.2.Resident #32 had diagnosis that included dementia, protein-calorie malnutrition, and reduced mobility. The Minimum Data Set, dated [DATE] documented Resident #32 had severe cognitive impairment, understood, and usually understands others. Resident #32 required substantial/maximal assistance with personal hygiene, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathing, and dressing.The current comprehensive care plan dated 04/01/2026 documented to monitor skin changes daily during care, skin and feet check with daily care, document weekly on shower day.The Order Summary Report printed 04/20/2026 documented an active order that was started on 07/15/2025 for bath/shower every evening shift every Tuesday with complete Skin Inspection; clean/trim nails.Review of the Treatment Administration Record dated 04/1/2026 - 04/30/2026, documented order for 3-11 bath/shower every evening shift every Tuesday, complete Skin Inspection that was signed off as completed by Licensed Practical Nurse #7 on 04/14/2026.Quality Improvement Skin Inspection for Resident #32 dated 04/13/2026 documented no skin issues.During an observation on 04/14/2026 at 12:46 PM, Resident #32 was sitting in their wheelchair in the dining room eating lunch and the resident had an approximate three (3) inch long, multicolored bruise over their entire left elbow. Resident #32 was unable to state what happened.During a telephone interview on 04/15/2026 at 11:00 AM, Resident #32's emergency contact stated they were not aware of any recent injuries or bruises to Resident #32.During an observation on 04/16/2026 at 11:05 AM, Resident #32 was sitting in their wheelchair with left arm along their left side and holding their left elbow with their right hand. Resident #32 was wearing long sleeves and bruise was unable to visualize at that time.During an interview and observation on 04/16/2026 at 4:28 PM-4:35 PM, Certified Nurse Aide #4, who was assigned to Resident #32 during day shift stated they provided morning care to Resident #32 and got them out of bed that morning. They stated they had not observed any bruise recently to Resident #32 skin. Resident #32 was lying in bed and upon Certified Nurse Aide #4 pushing left sleeve up on shirt, bruising to left elbow was present. Certified Nurse Aide #4 stated the bruising to Resident #32's left elbow looked recent, and they should have noticed it during hands on care but had overlooked it.During an interview on 04/16/2026 at 4:37 PM, Licensed Practical Nurse #7 stated nursing staff should be inspecting residents' skin on their shower days and during routine care.During a telephone interview on 04/17/2026 at 12:30 PM, Certified Nurse Aide #5 stated they gave Resident #32 their shower on Tuesday, 04/14/26 during the evening shift. They stated the date 04/13/26 on the skin inspection sheet was incorrect. Certified Nurse Aide #5 stated they did not recall seeing any bruises on Resident #32's left elbow. They stated if they had seen any bruising they would have reported it to the nurse immediately.During a follow up interview on 04/17/2026 at 1:49 PM, Licensed Practical Nurse #7 stated they recalled completing the skin check on Resident #32 on Tuesday, 04/14/2026, while they were in the shower room. They stated the lighting in the shower room was poor and if Resident #32's bruise to their left elbow was there, they must have missed it. Licensed Practical Nurse #7 stated they should have noticed the bruising because they were checking skin head to toe.During an interview on 04/17/2026 at 3:50 PM, Licensed Practical Nurse #4 Unit Coordinator stated skin inspections were expected to be completed on the resident's shower day, and any issues should be brought to them or a nursing supervisor's attention as soon as possible. They stated they expected the nurse to complete the skin inspection to be visualizing the resident's skin to identify any skin issues, including bruises.During an interview on 04/17/2026 at 4:41 PM, the Director of Nursing stated their expectation was that a head-to-toe assessment for any skin disruptions (rash, bruising, skin tears) was completed during the resident's weekly skin inspection to ensure skin integrity was being maintained. They stated resident skin should also be checked during hands on care as well. The Director of Nursing stated Resident #32's bruise to their left elbow should have been observed during their skin inspection on 04/14/26, if it was present, and did not know why it was not.3.Resident #58 had diagnoses that included diabetes mellitus, dementia, and osteoarthritis (a condition that affects your joints). The Minimum Data Set, dated [DATE] documented Resident #58 was cognitively intact, was understood and understood by others.The current comprehensive care plan dated 03/20/2026 documented Resident #58 was independent for decision making skills. Interventions included but not limited to able to self-administer medications as ordered/stored at bedside. The comprehensive care plan was not revised until 04/20/2026 to specifically include Tylenol may be self-administered as ordered and stored at bedside.The Nursing Self Medication Administration Data Collection Tool dated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/09/2026 documented the tool would be reviewed by the Interdisciplinary Team to determine if self-administration was clinically appropriate and would document their decision on the resident's care plan. If applicable, there would be a written order from the attending physician for the specific medications which could be self-administered. Further review of the Data Collection Tool documented Resident #58 was deemed safe for medication self-administration and the specified medications included inhalers and artificial tears (eye drops used for dry eyes).During intermittent observations on 04/14/2026 at 9:33 AM, 04/15/2026 at 9:31AM, and 04/20/2026 at 9:04 AM, Resident #58 was observed to have a bottle of Extra Strength Tylenol 500 milligram tablets located on their bedside table.During an observation and interview on 04/17/2026 at 8:50 AM, Resident #58 was observed in their room, and the same bottle Extra Strength Tylenol was observed on the resident's bedside table. Resident #58 stated their family had supplied the medication and they took two (2) pills every night for pain. Resident #58 stated the nursing staff was aware they had their own bottle of Tylenol and that they took the medication at night. Resident #58 stated it was documented on their care plan to have the medication at bedside.The Order Review Report dated 04/01/2026 - 04/30/2026 revealed a physician order for Acetaminophen (Tylenol) Tablet 500 milligrams, give two (2) tablets by mouth every eight (8) hours as needed for pain. The order start date was documented as 03/20/2026 and did not indicate Resident #58 may self-administer or keep the medication at bedside.Review of the Medication Administration Record dated 04/1/2026- 04/30/2026 revealed there was no documented evidence that Resident #58 had the ability to self-administer Tylenol prior to 04/20/2026 and there were no PRN (as needed) doses of Tylenol signed as administered by the nursing staff.During an interview on 04/20/2026 at 9:13 AM, Licensed Practical Nurse #8 stated residents that were allowed to self-administer medications would have a physician's order in the electronic medical record. Licensed Practical Nurse #8 reviewed Resident #58's medication administration record and stated they did not have a current order to self-administer or keep any medication at bedside. They stated Resident #58 was alert and oriented and believed they used to have an order to self-administer their inhalers and Tylenol in the past but did not have a current order. They stated they were not aware Resident #58 had a bottle of Tylenol on their bedside table and would notify their Unit Coordinator because there needed to be an order.During an interview on 04/20/2026 at 9:24 AM, Licensed Practical Nurse #4 Unit Coordinator stated if a resident wanted to self-administer a medication, they would need to be evaluated for their knowledge of the medication and if they could safely administer a medication. They stated if the evaluation determined a resident could self-administer medications it would be documented on their care plan and did not need a physician's order. Licensed Practical Nurse #4 Unit Coordinator stated Resident #58 was care planned to self-administer and store medications at bedside. They stated all questions on the Self Medication Administration Data Collection Tool completed on 04/09/2026 for Resident #58 were answered as yes which indicated the resident was able to safely self-administer medications and could keep medication bottles at the bedside.During an interview on 04/20/2026 at 9:43 AM, the Medical Director stated they would expect to be notified by the nursing staff if a resident wanted to self-administer medications. They stated a resident would need to have an assessment completed prior to allowing them to self-administer medication to determine if self-administration was safe and any over-the counter medications would need to be stored in a locked box in their room. The Medical Director stated there needed to be a physician's order for residents to self-administer any medication including eye drops, inhalers, and Tylenol. They stated if a resident had their own supply of Tylenol at bedside, they would expect the nurses to educate the resident to inform staff when the medication was taken and document the dose that was self-administered. They stated the nurses would need to ensure residents were not exceeding the maximum dose of three (3) grams of Tylenol in 24 hours.During an interview on 04/20/2026 at 11:17 AM, the Director of Nursing stated when a resident expressed the desire to self-administer medication, a self-medication administration evaluation tool was completed by the nursing team. They stated the evaluation was geared to medications being stored in a resident's (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Hill Nursing Facility, L L C	2699 Wehrle Drive Williamsville, NY 14221

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room, their ability to open bottles and to safely administer the medication. The Director of Nursing stated there would need to be a physician order obtained for the medication that was to be self-administered, the order would indicate it was the residents' own supply and may be self-administered. They stated a self-medication evaluation tool had been completed for Resident #58 and indicated they were able to self-administer and store medications at bedside. The Director of Nursing stated Resident #58 needed to have a physician order in place to have their own supply of Tylenol stored at bedside and did not. They also stated there were no active physician orders to self-administer any medications. The Director of Nursing stated Resident #58's Tylenol order needed to be updated to indicate may self-administer, additionally they would expect the nurses to verify and document when Resident #58 self-administered medication to know how much was being consumed.During an interview on 04/21/2026 at 11:18 AM, the Administrator stated residents who were deemed appropriate to self-administer medications would be able to do so to promote a homelike environment. They stated Resident #58 was evaluated and deemed appropriate to self-administer medications, however the nursing staff should have obtained a physician order to self-administer Tylenol. The Administrator stated it was expected that whenever staff found medications in a resident room, they would notify the unit coordinator to ensure an evaluation was completed, the care plan was updated, and that a physician order was obtained.10 New York Codes, Rules, and Regulations 415.12

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the survey, the facility failed to ensure developed and prepared menus to meet resident choices including their nutritional, religious, cultural, and ethnic needs were met for one (1) of four (4) dining rooms. Specifically, Resident's #17, #52, and #119 were not served with all the fluids and/or food items listed on their meal tickets and Resident #52 was not provided with their inner lip plate as documented on their meal ticket.The findings include: The policy and procedure titled Dining Rooms/Servery Meal Service revised 3/2011 documented that dietary personnel will assemble each resident's tray according to the menu and any special requests as stated on each diet card in accordance with the diet order. Nursing personnel will be responsible for disbursement of meals beginning with providing appropriate beverages and reviewing the menu with the residents. The tray card, which is labeled with resident's name, diet order, adaptive equipment and feeding status, is placed at the resident's place setting. Designated personnel will visually check each tray for accuracy. The policy and procedure titled Hydration revised 10/2023 documented each resident is provided with sufficient fluid intake to maintain proper hydration and health. The Dietician assesses all residents for fluid needs and adequate fluids to meet hydration needs are provided with each meal. The policy and procedure titled Adaptive Eating Equipment dated 1/1/2000, documented all residents requiring adaptive equipment will be issued the appropriate equipment to promote independence and maintain functional status. The Dietary Department will be responsible for seeing that adaptive equipment was supplied for residents' use at mealtimes.1.Resident #17 had diagnoses of type 2 diabetes mellitus, schizophrenia (mental disorder) and dysphagia (difficulty swallowing). The Minimum Data Set (a resident assessment tool) dated 02/10/2026 documented Resident #17 was severely cognitively impaired, usually understood, and sometimes understands. Required supervision with eating. The current comprehensive care plan dated 02/28/2026 documented at risk for alteration in nutrition, and dehydration. Interventions included: meal plan provides kilocalorie/protein/fluid in excess of needs and meets/exceeds dietary reference intakes for vitamins/minerals; provide preferred fluids via meal plan, adjust as needed; and adjust meal plan as needed. During an observation on 04/16/2026 at 9:12 AM Resident #17's meal ticket documented for two (2) pancakes and two (2) sausages. Resident #17 received scrambled eggs, sausage and toast. During an interview at the time of the observation, Resident #17 stated they would have liked to have received pancakes. Upon surveyor notifying nursing staff that the resident would like pancakes the Dietary Supervisor #1 stated that Resident #17 receives the same breakfast every day, eggs, sausage and toast. Resident #17 was provided with two pancakes and consumed an entire pancake in addition to their eggs, sausage, and toast. During an observation on 04/20/2026 between 8:56 AM and 9:20 AM, Resident #17 meal ticket documented eight (8) ounce coffee, four (4) ounce juice and eight (8) ounce milk. Resident #17 was observed to only be provided with an eight (8) ounce cup of milk. Upon leaving dining room, Resident #17 stated they did not want coffee, but they would have liked to have received juice and did not. 2. Resident #52 had diagnoses of cardiovascular incident (stroke) with hemiplegia (weakness or paralysis), aphasia (difficulty speaking) and dementia. The Minimum Data Set, dated [DATE] documented Resident #52 was severely cognitively impaired and required supervision with eating. The current comprehensive care plan date 03/11/2026 documented Resident #52 was self-performance deficit for eating related cardiovascular incident and interventions included adaptive equipment of inner lip plate. The care plan documented Resident #52 was at risk for alteration in nutrition. Interventions included having a four (4) once mighty shake with meals; meal plan provides kilocalorie/protein/fluid in excess of needs and meets/exceeds dietary reference intakes for vitamins/minerals and adjust meal plan as needed. The care plan also documented Resident #52 was at risk for dehydration related to suboptimal fluid intake with (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions for hydration protocol. During an observation on 04/17/2026 from 8:23 AM to 9:40 AM, Resident #52 was in the dining room for the breakfast meal. Their meal ticket documented two (2) cinnamon pastries, eight (8) ounce water, four (4) ounce prune juice, two (2) eight (8) ounce house juice and four (4) ounce mighty shake. The meal ticket also documented the resident required an inner lip plate. Resident #52 received scrambled eggs, toast, oatmeal (in a bowl) on a regular plate. Resident #52 was drinking an eight (8) ounce chocolate milk. There were no pastries or any other beverages provided. During an observation on 04/17/2026 at 12:35 PM, Resident #52 was in the dining room for the lunch meal. Their meal ticket indicated two eight (8) ounce water, four (4) ounce prune juice, two (2) eight (8) ounce house juice and four (4) ounce mighty shake. Resident #52 was drinking an eight (8) ounce chocolate milk, and no other beverages were provided. During an observation on 04/20/2026 between 8:46 AM and 9:32 AM, Resident #52 was in the dining room for their breakfast meal. Their meal ticket documented two (2) cinnamon pastries and banana with adaptive equipment of an inner lip plate. Resident #52 was served eggs, toast and oatmeal (in a bowl) on a regular plate. There were no pastries or bananas provided. 3. Resident #119 had diagnoses of type 2 diabetes mellitus, cardiovascular incident with hemiplegia, and dementia. The Minimum Data Set, dated [DATE] documented Resident #119 was moderately cognitively impaired, usually understood, and usually understands and required supervision with eating. The current comprehensive care plan dated 01/28/2026 documented Resident #119 was at risk for alteration in nutrition. Interventions included meal plan provides kilocalorie/protein/fluid in excess of needs and meets/exceeds dietary reference intakes for vitamins/minerals. The care plan documented Resident #119 was at risk for dehydration related suboptimal fluid intake. During an observation on 04/14/2026 at 12:07 PM Resident #119 was in the dining room for the lunch meal. Their meal ticket documented they should have received four (4) ounce prune juice, eight (8) ounce chocolate milk, eight (8) ounce coffee and eight (8) ounce house juice. Resident #119 only received eight (8) ounce cup of juice, which they had consumed one hundred percent. No additional fluids were provided. During an observation on 04/20/2026 between 8:50 AM and 9:21 AM, Resident #119 was in the dining room for the breakfast meal. Their meal ticket documented they should have received four (4) ounce prune juice, eight (8) ounce whole milk, eight (8) ounce coffee and eight (8) ounce house juice. Resident #119 only received eight (8) ounce cup of juice. During an interview at the time of the observation Resident #119 was asked by surveyor if they would have liked their milk and coffee and the resident replied yes. During an interview on 04/20/2026 at 9:08 AM, the Dietary Supervisor #1 stated they have been working at the facility for many years, and they are familiar with all the residents, and they know what they like and how they like it. They stated they did not provide Resident #52 with the banana nor pasties because a lot of times they do not eat it. The Dietary Supervisor #1 stated they did not serve Resident #52 meal on an inner plate, but they should have. During an interview on 04/20/2026 at 9:17 AM, Licensed Practical Nurse #6 stated residents should be offered items on their meal tickets. They stated residents should at least be asked, offered beverages on meal tickets to see if they would like them. They stated residents have a choice about what they want to eat and drink. Licensed Practical Nurse #6 stated they were not sure who determined what beverages residents were to receive. During an interview on 4/20/2026 at 9:27 AM, Certified Nurse Aide #3 stated the resident's meal ticket should be looked at to determine what the resident was to receive to eat and drink. They stated it was important for residents to receive what was on their meal ticket for nutrition purposes. They stated if a resident did not receive their drinks indicated on their meal ticket, they could feel parched, their mouth could be dry, they could become dehydrated and could choke if they did not have enough fluids to wash down their food. During an interview on 04/20/2026 at 9:38 AM, Licensed Practical Nurse #4 stated nursing staff should be serving what was indicated on the residents' meal tickets. They stated they would expect all fluids to be offered and that nursing staff typically asked residents what they wanted to drink. They stated the dietician determines preferences and amounts to be served to prevent dehydration and ensure residents were getting enough calories. During an interview on 04/20/2026 at (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:49 AM, Registered Dietician #1 stated they would expect residents to receive food and fluids documented on their meal ticket unless they tell the server they do not want something. They stated substitutions for food and fluids were on the fly, but items on the meal ticket should at least be offered. They stated it was important for residents to receive adequate fluids to prevent dehydration. The Registered Dietician stated residents who were confused should be receiving what was on their meal ticket for hydration purposes, as they cannot communicate what they need. During an interview on 04/21/2026 at 9:17 AM, Occupational Therapist #1 stated Resident #52 utilized only one hand for eating due to their stroke and did not like staff to assist them with eating. They stated Resident #52 was recommended for an inner lip plate to make it easier for the residents to scoop their food. During an interview on 04/21/2026 at 9:34 AM, the Food Service Director stated they would expect the dietary staff to serve residents what was stated on their meal ticket unless the residents stated they wanted something different. The Food Service Director stated the dietician makes a resident's menu per the resident's preference and what their meal needs were, and the dietary staff should not change that menu without speaking to the dietician. They stated the staff members that were serving the food were responsible for plating the food on the appropriate adaptive equipment. They stated that if the meal ticket documented Resident #52 was to have a scoop plate, then that was what should have been given. During an interview on 04/21/2026 at 11:27 AM, the Director of Nursing stated after review of Resident #52's Kardex (guide used by staff to provide care) in the electronic medical record, that Resident #52 was care planned to have an inner lip plate at meals. They stated they would expect staff to use that adaptive equipment because it was part of the care plan. The Director of Nursing stated they would expect the meal tickets to be followed, unless the residents expressed differently. They stated the standard was for the meal ticket to be followed and for the nursing staff to notify the dietician if the meal tickets needed to be altered. They stated it was important for residents to receive food/fluids as indicated to support their nutritional needs. 10 New York Codes, Rules, and Regulations (NYCRR) 415.14 (c) (3)

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NAME OF PROVIDER OR SUPPLIER Harris Hill Nursing Facility, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 2699 Wehrle Drive Williamsville, NY 14221	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews conducted during the survey, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for two (2) (Unit A and Unit D) of four (4) unit servery refrigerators. Specifically, the unit servery refrigerators contained unlabeled, out-of-date food and drink items, and personal food was stored with residents' food. In addition, Unit A servery floor was soiled with food debris/dried spills and Unit D's refrigerator's handle was sticky with an unknown substance, and the front was soiled with food debris. The findings included: The policy titled Food Receiving and Storage revised on 12/2012 documented all opened items will be labeled and dated and discarded after three (3) days once they were opened. All Non-Potentially Hazardous Foods (PHF) or Time/Temperature Control for Safety (TCS) food items will be labeled and dated and discarded after five (5) days once opened. The policy titled Food Preparation, Service and Distribution revised on 10/2022 documented the facility will assure safe and sanitary food preparation, and distribution to prevent foodborne illness. 1.During an observation of the Unit D servery area and refrigerator/freezer on 04/14/2026 at 9:49 AM the following was observed: -the handle of the refrigerator was sticky with an unknown substance and the front of refrigerator had streaks of food debris.-one (1), clear plastic bag of sliced cold cut bologna, dated 04/07/2026.-one (1), clear plastic bag of sliced cold cut ham, dated 04/07/2026.-one (1), clear disposable plastic container of egg salad, undated.-one (1), clear disposable plastic container of sliced tomatoes, undated.-one (1), clear plastic bag of sliced cold cut turkey, dated 04/09/2026-one (1), clear plastic bag of sliced cheese, dated 04/07/2026.-two (2), 64-ounce clear pitchers of juice, undated. 2.During an observation of the Unit A servery and refrigerator/freezer on 04/17/2026 at 10:30 AM the following was observed: -food debris, crumbs, along back wall, and under stainless steel counter. Floor tacky with dried spills. Buildup of a black substance on floor in front of refrigerator.-one (1), 16.9 fluid ounce bottle unopened, unlabeled personal iced tea.-one (1), 16 ounce (one pound) of margarine opened, used and undated.-one (1), 64-ounce clear pitcher of orange juice with tape labeled on lid 4/14-one (1), 64-ounce clear pitcher of apple juice with tape labeled on lid 4/14-one (1), half gallon of milk opened, and undated with sell by date of April 17, 2026.-one (1), half gallon of chocolate milk opened and undated with sell by date of April 23, 2026.-one (1), clear disposable plastic container of egg salad dated 04/13/2026.-slices of cheese wrapped in clear plastic wrap dated 04/13/26.-one (1), clear disposable plastic container of fresh fruit (melon, grapes) dated 04/14/2026. -two (2), eight (8) ounce cups of juice with lids and straws, undated in door of refrigerator. -one (1), clear plastic baggie undated, unlabeled with bagels in drawer of refrigerator.-one (1), clear plastic baggie undated, unlabeled with raisin bread in drawer of refrigerator.-two (2), clear plastic baggies undated, unlabeled with English muffins in drawer of refrigerator.-three (3), eight (8) ounce cups of chocolate milk with lids and straws, undated in door of refrigerator.-three (3), 16.9 fluid ounce, frozen, plastic water bottles unlabeled in the freezer.-one (1), eight (8) ounce aluminum can of ginger-ale opened, unlabeled in freezer. During an interview on 04/17/2026 at 10:48 AM, Dietary Aide #1 stated food/drink items labeled/dated in the refrigerator were good for four (4) to five (5) days. They stated they were responsible for checking dates to make sure items did not need to be thrown away. They stated food/drink items dated 04/16/20 would be good until Monday, 04/20/2026. They stated unless drink items were dated, no one would know when they were poured. They stated everything should be dated, so everyone knows when it was from and when it should be gotten rid of. They stated personal items should not be stored in the servery refrigerator. Dietary Aide #1 stated the pitcher of orange juice dated 04/14/2026 did not look good, and they would stay away from using something dated from over three (3) days old. They were not sure how long milk containers were good for once opened and dated but should be dated to make sure they were not serving residents something old. Dietary Aide #1 stated the floors were supposed to be swept between meals and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mopped every night. They stated the floor was not free of food debris and the floor needed to be mopped. They stated it was important to keep the servery clean for sanitation purposes. They stated debris builds up fast, was unsanitary and could attract rodents. During an interview on 04/17/2026 at 11:07 AM, Dietary Supervisory #1 stated the dietary supervisors should be checking that the dietary aides were checking dates and discarding food/drink items. They stated anything open was supposed to be dated, so they knew when it needs to be discarded. They stated food/drink items once opened, were good for three (3) days, three-day survival. They stated there should be no personal items stored in the refrigerator and should be labeled if it belongs to a resident. Dietary Supervisory #1 stated there should be no food debris, spills on floor and that there needs to be a better job done of sweeping and mopping the floor. During an interview on 04/17/2026 at 11:33 AM, the Food Service Director stated the dietary supervisors were responsible for checking the refrigerators/freezers in the serveries to make sure nothing was expired and that all food/drink items were dated, labeled every morning. They stated it was important that everything was dated, labeled to prevent food borne illness. During an interview on 04/21/2026 at 10:48 AM, Dietary Aide #2 stated it was important for food/drink items to be dated when they were opened because they only have a three (3) to five (5) day shelf life. After the three (3) to five (5) day shelf life they were disposed of because of bacterial growth. Dietary Aide #2 stated it was important to keep food prep areas clean to keep pests away. During an interview on 04/21/2026 at 11:51 AM, the Director of Nursing stated food is supposed to be labeled and dated when opened to make sure expired items were not being used. During an interview on 04/21/2026 at 1:01 PM, the Food Service Director stated cleaning of the servery areas was dietary and housekeeping's responsibility and that the dietary supervisors should ensure the dietary aides were completing what was required to maintain a clean, sanitized servery. They stated the serveries were supposed to be swept three times a day, after each meal, and mopped every night. They stated hygiene was key in every step because they would not want to eat out of someplace that was dirty. During an interview on 04/21/2026 at 1:12 PM, the Administrator stated all food/drinks should be labeled and dated to prevent any issues with spoilage that could cause complications to residents. They stated they expected a clean environment. 10 New York Codes, Rules, and Regulations (NYCRR) 415.14 (h)