

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Elderwood at Amherst		STREET ADDRESS, CITY, STATE, ZIP CODE  4459 Bailey Ave Amherst, NY 14226	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48626</p> <p>Based on observation, interview, and record review conducted during the Abbreviated Survey (Complaint #NY00347516) the facility did not ensure they treated each resident with respect and dignity, and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for one (Resident #2) of three residents reviewed. Specifically, Resident #2 was treated by Certified Nurse Aide #1 in an undignified manner during care. Resident #2 told Certified Nurse Aide #1 they were hurting their arms by rushing them; Certified Nurse Aide #1 threw their clothes at them and stated, well then put them on yourself.</p> <p>The finding is:</p> <p>The policy titled Resident's Rights, last modified 6/6/2022, documented that each staff member will be personally responsible for ensuring that the rights of each resident are respected and not violated. Staff shall ensure that all residents are afforded their right to a dignified existence, in treatment and care.</p> <p>The policy titled Dignity, last modified 8/1/2019, documented each resident has the right to be treated with dignity and respect. All interactions with residents by any staff must focus on assisting the resident in maintaining and enhancing their self-worth. When providing care and services, staff must respect each resident's individuality, as well as honor and value their input.</p> <p>Resident #2 had diagnoses including spinal stenosis of the lower back (narrowing of an area in the spine, causes back pain), need for assistance with personal care, and unspecified dementia. The Minimum Data Set (a resident assessment tool) dated 5/22/24, documented Resident #2 was cognitively intact, always understood and always understands. They did not reject care, and they required partial/moderate assistance with upper body dressing.</p> <p>The comprehensive care plan, dated 7/8/24, documented Resident #2 had an Activities of Daily Living functional deficit related to their spinal stenosis and required one-person physical assistance with upper body dressing.</p> <p>The Kardex (a guide staff use to provide care) dated 7/8/24, documented Resident # required one-person partial/moderate assistance with upper body dressing.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility investigation, dated 7/8/24, revealed the Director of Nursing (current Acting Administrator) interviewed the resident and completed a grievance/Concern/Compliment Log Form, on 7/8/24. Resident #2 stated they had been assisted onto the toilet by Certified Nurse Aide #1, they began to take their shirt off, they told the Aide they were hurting their arms, the aide proceeded to throw the clothing at them and replied, then put them on yourself and walked away. The Director of Nursing interviewed Certified Nursing Aide #1 on 7/8/24. The Aide stated the resident was difficult they apologized for hurting their arms, then walked away and let them be. Certified Nurse Aide #1 was terminated on 7/8/24 for unsatisfactory resident care, resident abuse, or failure to follow a care plan, and being insubordinate to a supervisor/manager.</p> <p>During an observation and interview on 1/15/25 at 3:17 PM, Resident #2 was seated in their wheelchair in their room, dressed and well groomed, watching TV. Resident #2 stated they did recall the incident with Certified Nurse Aide #1. They stated that was a while ago but recalled that they were trying to get ready for bed and the Aide was rushing them. They stated it made them feel bad for needing help. They were in a nursing home because they couldn't take care of themselves, and Certified Nurse Aide #1 made them feel like they were a burden and moved too slow. That was why they told someone about it, it just wasn't the right way to treat people. Resident #2 stated they did not feel they were physically abused but they felt it was undignified to be treated that way. They were not fearful of staff and felt safe in the facility. The facility responded quickly to their concern, and they never saw the Aide again after that.</p> <p>During a telephone interview on 1/16/25 at 10:41 AM, Certified Nurse Aide #3 stated they worked on the unit where Resident # 2 lived, but they did not recall the incident with Certified Nurse Aide #1. They stated it would not be right to toss a resident's clothing at them and tell them to dress themselves. That would be very undignified. Most of their residents were in the nursing home because they couldn't dress themselves. They shouldn't make them feel bad about that.</p> <p>During a telephone interview on 1/16/25 at 1:07 PM, Certified Nurse Aide #1 stated they recalled caring for Resident #2, they stated Resident #2 was always difficult to deal with because they wanted things done their way. Certified Nurse Aide #1 stated they were new to the resident and didn't know how they liked things done yet. They stated that when the resident got frustrated with them, they thought they should walk away and re-approach later, after they calmed down. They did not feel they mistreated the resident. They stated they did return to the resident after they calmed down, got them dressed and into bed. They felt the Director of Nursing wanted them fired, so that was a good excuse to do it.</p> <p>During an interview on 1/16/25 at 1:20 PM, Certified Nurse Aide #2 stated they never witnessed Certified Nurse Aide #1 being physically abusive but thought Certified Nurse Aide #1 was not patient with the residents and got frustrated easily. They were taught to treat residents like this was their home and they were a guest, that was not how Certified Nurse Aide #1 acted.</p> <p>During an interview on 1/16/25 at 1:25 PM, Registered Nurse #1 stated it would be very undignified to toss a resident's clothing at them and tell them to dress themselves. The residents were there because they couldn't care for themselves, it was terrible to make them feel bad about that.</p> <p>During an interview on 1/16/25 at 1:40 PM, The Acting Administrator (previous Director of Nursing) stated Certified Nurse Aide #1 did not treat Resident #2 with dignity and respect. The Certified Nurse Aide was terminated for their mistreatment of Resident #2.</p> <p>(continued on next page)</p>		

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