| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335056 | A. Building<br>B. Wing | 12/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Elderwood at Amherst | 4459 Bailey Ave<br>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) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a Complaint investigation (#2675690) during an Abbreviated survey completed on 12/04/2025, the facility did not ensure the resident's right to be free from physical and mental abuse for two (2) (Residents #1 and #2) of three (3) residents reviewed. Specifically, Certified Nurse Aide #1 attempted to redirect Resident #1, a wandering resident to a seated position. The physical handling during this process was observed as aggressive. Resident #1 lost their balance, fell to the floor, and sustained a small abrasion to their side. A physical struggle occurred after Resident #2 unplugged a power cord; Certified Nurse Aide #2 responded aggressively, moving the resident against a wall to recover the cord. In addition, Certified Nurse Aide #2 restricted Resident #2's movement and taunted the resident leading to continued agitation. Even though the residents did not have a reaction/recall to the staff's inappropriate interactions, it can be determined that the reasonable person would experience no actual harm with the potential for more than minimal psychosocial harm as a result of the inappropriate interactions by staff. The findings are:The policy titled Abuse Prevention, Identification, Investigation, Protection and Reporting revised 04/30/2024 documented, the facility will provide protection for the health, welfare and rights of each resident residing in the facility. The facility will have procedures to prevent and prohibit all types of abuse, mistreatment, neglect, misappropriation of resident property and exploitation. The policy titled Abuse Reporting Guide: Identification and Reporting Alleged Violations of Abuse, Neglect, Mistreatment, Injuries of Unknown Source, Misappropriation and Exploitation, undated, documented: Examples of mental / verbal conflict - include intimidation, bullying - aggressive behavior in which someone intentionally and repeatedly causes another resident mental anguish or discomfort. Examples of physical altercations willful actions include, but are not limited to the following, hitting, grabbing, shoving. 1.Resident #1 had diagnoses including dementia (the loss of cognitive functioning, thinking, remembering and reasoning to such an extent that it interferes with a person's daily life and activities), anxiety disorder (a mental health condition characterized by intense, excessive and persistent worry or fear about everyday situation interfering with daily life, work and relationships), and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 09/23/2025 documented that Resident #1 had moderate cognitive impairment, sometimes understood, sometimes understands, was able to ambulate once standing with supervision or touching assistance (helper provides verbal cues and / or touching/steadying and/or contact guard assistance as resident completes activity. Resident #1's comprehensive care plan, identified as current by Director of Nursing #1, documented the resident had a deficit in activities of daily living and mobility. Interventions included the resident walked 150 (one hundred fifty feet) with supervision or touching assistance with rolling walker and cueing for direction. The resident had the potential for alteration in their mood/behavior related to dementia, interventions included to approach resident from the front in a calm gentle manner, explain all aspects of care prior to care, if resident becomes agitated, stop, ensure safety and re-approach; monitor environment stimuli, adjust as needed; and redirect, intervene and/or provide distraction during episodes of agitation. Resident #1's Bedside Kardex Report (guide used by staff to provide care) 11/24/2025 documented the resident walked 150 (one hundred fifty) feet with supervision or touching assistance as needed, cuing for direction. There were no interventions regarding what to do if the resident has altered mood/behavior. Review of facility's incident report dated 11/21/2025 documented, Resident #1 had a witnessed fall, was observed to land on the floor while the certified nurse aide was with the resident. It was reported by staff watching the camera footage. Resident was transferred to the chair by the aide. A note on the form dated 11/22/2025 documented on the morning after the fall, staff observed a reddened area to the right flank (side) of resident. The area was noted to be superficial and not bleeding. The resident showed no signs or symptoms of pain or discomfort. Resident #1's Skin assessment dated [DATE] at 9:33 AM documented Resident #1 had a 3.5 centimeter by (x) 1.2 centimeter abrasion on their right flank, in-house acquired on 11/21/2025, new intervention included triple antibiotic ointment followed with a dry clean dressing daily. During observations on 12/03/2025 at 11:55 AM and 12:31 PM, Resident #1 was sitting in the unit dining room at table with two (2) other residents, no concerns were observed. During an interview on 12/03/2025 at 12:35 PM Resident #1 denied any concerns related to abuse, mistreatment or neglect. 2. Resident #2 had diagnoses including dementia, Parkinson's Disease (a progressive movement disorder of the nervous system), and osteoarthritis (a degenerative joint disease where joint cartilage breaks down |