

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2024
NAME OF PROVIDER OR SUPPLIER  Elderwood at Williamsville		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Bassett Road 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22485</b></p> <p>Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00339512) completed on 4/23/24, the facility did not ensure that all alleged violations including abuse, neglect, exploitation or mistreatment were reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegation involved abuse, to the facility's Administrator and the State Survey Agency for one (Resident #1) of three residents reviewed. Specifically, facility staff did not report an allegation of abuse/mistreatment of a resident to the Director of Nursing or the Administrator which resulted in the alleged abuse not getting reported to the appropriate officials including the New York State Department of Health as required.</p> <p>The finding is:</p> <p>The policy and procedure titled Abuse Prevention, Identification, Investigation, Protection, and Reporting dated 3/25/24 documented upon identification of an observed act of abuse or mistreatment all staff members are required to report the observation immediately to their direct supervisor, the Director of Nursing or Administrator so an investigation can begin.</p> <p>Resident #1 had diagnoses including dementia, major depressive disorder, and high blood pressure. The Minimum Data Set, dated dated dated [DATE] documented the resident had severely impaired cognition and had physical and verbal behaviors directed toward others daily.</p> <p>The comprehensive care plan dated 4/11/24 documented Resident #1 required total assistance of two with toileting and had an alteration in their mood/behavior related to dementia with agitation. Interventions included to provide verbal cues prior to care routines, redirect/intervene provide distraction during episodes of agitation and reapproach when appropriate.</p> <p>The Investigation Summary Guide signed by the Director of Nursing on 4/23/24, documented on 4/16/24 Certified Nurse Aide #1 reported that Certified Nurse Aide #2 grabbed Resident #1's nose and shook their head. The investigation documented this incident was reported to the New York State Department of Health on 4/17/24.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a written statement included with the facility's investigation, signed by Certified Nurse Aide #1 dated 4/17/24, documented on 4/16/24 around 4:00 PM they witnessed Certified Nurse Aide #2 grab Resident #1's arms and shake them when the resident became combative during care, then Certified Nurse Aide #2 grabbed Resident #1's nose and shook their head. Certified Nurse Aide #3 was also a witness.</p> <p>During a telephone interview on 4/23/24 at 11:06 AM, Certified Nurse Aide #1 stated on 4/16/24 while providing care to Resident #1 in their bathroom, Resident #1 became combative and they witnessed Certified Nurse Aide #2 grab the resident's arms, shake them, and say, we don't do that here. Then Certified Nurse Aide #3 arrived to help them get Resident #1 back into their wheelchair. Certified Nurse Aide #2 attempted to clean Resident #1's hands (because they had stuff on them) using hand sanitizer, the resident was still being combative, then Certified Nurse Aide #2 grabbed the resident's nose and shook their head. The Certified Nurse Aide #1 stated they did not tell the nurse about this, and they didn't think to tell the nurse at that moment. Certified Nurse Aide #1 felt that Certified Nurse Aide #2 overreacted and was extremely inappropriate and normally they would have reported something like this right away. The Certified Nurse Aide #1 stated they reported it the next day (4/17/24) before they started their shift.</p> <p>During an interview 4/23/24 at 2:37 PM, Licensed Practical Nurse #1 stated they did not witness any abuse and no staff reported any resident abuse or mistreatment to them when they worked on 4/16/24 during the evening shift. The Licensed Practical Nurse #1 stated they would expect staff to tell them right away if they witnessed any abuse or mistreatment of a resident. In this case, Certified Nurse Aide #1 should have reported it right away and hoped that staff would let them know if they ever felt uncomfortable about something going on. Licensed Practical Nurse #1 stated they considered the allegations made by Certified Nurse Aide #1 as abuse.</p> <p>During an interview on 4/23/24 at 3:40 PM, with the Assistant Director of Nursing present, the Director of Nursing stated Certified Nurse Aide #1 should have reported an incident like this immediately to their nurse or supervisor (on 4/16/24). If staff suspected someone of resident mistreatment, they should report it right away. They have in serviced their staff that abuse allegations should be reported right away. The Assistant Director of Nursing stated they wanted it reported right away because you don't want something else to happen.</p> <p>During an interview on 4/23/24 at 4:30 PM, the Administrator stated they don't know why Certified Nurse Aide #1 didn't report this allegation right away as required as this staff member had recent training. It was important that they reported it right away because they had believed abuse happened and an investigation could have been started.</p> <p>10 NYCRR 415.4(b)(2)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22485</b></p> <p>Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00339512) completed 4/23/24, the facility did not ensure that all alleged allegations of abuse, were thoroughly investigated for one (Resident #1) of three residents reviewed. Specifically, the facility did not complete a thorough investigation into an allegation of staff to resident physical abuse that included interviews or monitoring of other residents the accused staff member had cared for.</p> <p>The finding is:</p> <p>The policy and procedure titled Abuse Prevention, Identification, Investigation, Protection, and Reporting dated 3/25/24 documented all allegations of abuse and mistreatment will be investigated. The investigation will include, but not limited to identifying and interviewing all involved persons including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation.</p> <p>Resident #1 had diagnoses including dementia, major depressive disorder, and high blood pressure. The Minimum Data Set, dated dated dated [DATE] documented the resident had severely impaired cognition and had physical and verbal behaviors directed toward others daily.</p> <p>The comprehensive care plan dated 4/11/24 documented the resident required total assistance of two with toileting and had an alteration in their mood/behavior related to dementia with agitation. Interventions included to provide verbal cues prior to care routines, redirect/intervene provide distraction during episodes of agitation and reapproach when appropriate.</p> <p>The facility's Investigation Summary Guide signed by the Director of Nursing on 4/23/24, documented on 4/16/24 Certified Nurse Aide #1 reported that Certified Nurse Aide #2 grabbed Resident #1's nose and shook their head. The investigation documented this incident was reported to the New York State Department of Health on 4/17/24. The investigation documented the involved resident was not able to be interviewed and did not include interviews with any other residents Certified Nurse Aide #2 had cared for.</p> <p>Review of a written statement included with the facility's investigation, signed by Certified Nurse Aide #1 dated 4/17/24, documented on 4/16/24 around 4:00 PM they witnessed Certified Nurse Aide #2 grab Resident #1's arms and shake them when the resident became combative during care, then Certified Nurse Aide #2 grabbed Resident #1's nose and shook their head.</p> <p>During an interview on 4/23/24 at 3:40 PM, the Director of Nursing stated they were responsible for completing the investigation and they did not interview any other residents because it was a memory care unit, and the residents weren't reliable historians. The Director of Nursing stated that not asking other residents about their interactions with Certified Nurse Aide #2 was on them and felt they could have done a better investigation.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/23/24 at 4:30 PM, the Administrator stated they didn't know if any other residents were interviewed about their interactions with Certified Nurse Aide #2, but that would be part of the normal course of an investigation. The Administrator stated this was a memory care unit, so it would be difficult to get interviews and didn't think the accused staff member floated to other units. The Administrator stated there was a potential candidate on the memory care unit to interview and they should have been interviewed to determine the potential impact on other residents. The Administrator reviewed the facility's abuse policy and stated it didn't specifically include interviewing other residents and it probably should be included.</p> <p>Review of an untitled document, provided by the Assistant Director of Nursing on 4/23/24, documented Certified Nurse Aide #2 worked on different resident units in the facility on 4/5/24 and 4/13/24.</p> <p>10 NYCRR 415.4(b)(3)</p>		