

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  05/01/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review conducted during a Complaint Investigation (#NY00370991) the facility failed to protect residents from sexual abuse for one (1) (Resident #1) of three (3) residents reviewed. Specifically, Resident #1 was touched inappropriately by Resident #2.</p> <p>The policy and procedure titled Abuse Prevention, Identification, Investigation, Protection and Reporting dated 4/30/24 documented the facility will provide protection for the health, welfare and rights of each resident residing in the facility. The facility is responsible for prohibiting and preventing abuse of residents. The facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation. Actions will be taken to protect the resident from alleged perpetrators during an investigation. Examples may include room changes to protect the resident from the alleged perpetrator, increase supervision of the alleged victim.</p> <p>Review of the Lesson Plan-Education Fair 2025 Resident Rights and Abuse Reporting revealed sexual abuse includes sexual harassment, sexual coercion or sexual assault. Reportable incidents included, touching intimate body parts or clothing covering intimate body parts.</p> <p>The finding is:</p> <p>1. Resident #1 had diagnoses that included dementia, cerebral infarction (stroke), and aphasia (language disorder). The Minimum Data Set (a resident assessment tool) dated 12/4/24 documented Resident #1 rarely/never understood, rarely/never understands, and was severely cognitively impaired.</p> <p>The comprehensive care plan (current) dated 11/22/22 documented Resident #1 was deficit in activities of daily living function/mobility. Intervention initiated 12/14/23 documented total dependence of one assist with wheelchair mobility. Safety focus initiated 11/23/22 included intervention to provide safe environment. There was no care plan developed to address potential victimization or revisions after the sexual abuse on 2/3/25.</p> <p>Review of the Determination of Incapacity for Medical Decision-Making dated 12/2/22 revealed Resident #1 lacked the capacity to make own medical/health care decision and the reason for this lack of capacity was due to dementia.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #2 had diagnoses including dementia, major depressive disorder, and type 2 diabetes mellitus. The Minimum Data Set, dated [DATE] documented Resident #2 understood, usually understands and had moderate cognitive impairment. Additionally, the Minimum Data Set, dated [DATE] documented Resident #2 understood, understands and was cognitively intact.</p> <p>The comprehensive care plan revised 11/11/24 documented Resident #2 had the potential for alteration in their mood/behavior and was moderately impaired with decision making related to progressive disease process. Interventions included psychiatric consult as indicated and assess for changes in cognition. Additionally, Resident #2 had been ordered psychotropic medications related to dementia, depression and insomnia. Interventions included to monitor interaction of resident with others for appropriateness.</p> <p>Review of the Determination of Incapacity for Medical Decision-Making dated 2/11/25 revealed Resident #2 lacks the capacity to make own medical/ health care decisions due to dementia.</p> <p>The incident report dated 2/3/25 at 8:15 PM completed by Licensed Practical Nurse Supervisor #1 documented Licensed Practical Nurse #2 reported that Resident #2 was found by Certified Nurse Aide #1 touching Resident #1's breasts while in the atrium/dining room after dinner. The incident report documented both Resident #1 and Resident #2 were removed from the atrium/dining room. Resident #2 was asked to go into their room and a body check of Resident #1 was completed. Resident #2 when asked by Certified Nurse Aide #1 to stop touching Resident #1 they stated, What are you a nun?</p> <p>Review of an investigation statement dated 2/3/25 revealed Certified Nurse Aide #1 walked into the dining room and saw Resident #2 put their hand under Resident #1's shirt touching their breast. Certified Nurse Aide #1 stated Resident #1's right breast was showing.</p> <p>An investigation summary guide dated 2/6/25 completed by Interim Director of Nursing #1 concluded the facts in the investigation supported the allegation of sexual abuse as defined in the regulations. Sexual abuse can be touching intimate body parts or the clothing covering intimate body parts. Resident #1 had severe dementia and could not convey what happened, this is non-consensual sexual contact. Resident #2 had no recall of event. Follow up actions documented Resident #1, and Resident #2 were immediately separated. Resident #1 and Resident #2 live on separate hallways of unit. Staff monitored Resident #2 following the incident. Other residents residing on that unit were interviewed. Facility wide in-service related to incident. Resident #2 to see Psychiatry. Telephone conference with Resident #2's Health Care Proxy completed and decision made to move Resident #2 to different unit.</p> <p>Review of the medical professional progress note dated 2/4/25 at 7:20 AM by Physician Assistant #1 revealed Resident #2 was seen after incident with another resident with inappropriate touching. Resident #2 did not recall the incident, had no signs of pervasive thoughts, hallucinations or delusions on exam. Physician Assistant #1 documented Resident #2 was a poor historian secondary to dementia and did not have capacity to make complex medical decisions.</p> <p>Review of psychiatry consult completed 2/7/25 by Medical Doctor #1 documented Resident #2 had no recollection of their inappropriate behavior with another resident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 4/29/25 at 10:51 AM, Resident #2 was sitting in the recliner in their room and stated they had been at the facility for a week to recuperate. Resident #2 was unaware of the location of the facility. Resident #2 denied having any altercations with other residents. When asked if they touched another residents' breasts Resident #2 denied allegation but then stated, that's not a bad idea. Resident #2 then stated that they should not do that because they could get pissed. Additionally, Resident #2 stated if another resident touched them then it would be ok to touch them back.</p> <p>During an observation on 4/29/25 at 11:23 AM, Resident #1 was sitting in the unit atrium/dining room with the activity staff. Resident #1 was awake, smiling, babbling, mumbling incoherently. Resident #1 was not able to be interviewed.</p> <p>During an interview on 4/29/25 at 11:42 AM, Licensed Practical Nurse #3, Unit Manager stated they were never aware or concerned about any inappropriate behavior by Resident #2 prior to incident on 2/3/25. They stated Resident #2 was able to self-propel the wheelchair to all unit destinations and felt they knew right from wrong. Licensed Practical Nurse #3 stated a resident touching another resident's breast was considered physical/sexual abuse. They stated that Resident #1 was monitored for change in behaviors, any adverse effects from incident with Resident #2, and there were none.</p> <p>During an interview on 4/29/25 at 1:51 PM, the Director of Social Services stated they interviewed Resident #2 on 2/4/25 regarding the incident and they were blas&amp;eacute; (indifferent) about it, did not remember it, and changed the subject. They did not believe Resident #2 was aware of what they did. They stated they did not feel the incident was abuse because it was not determined to be intentional, and Resident #2 had no recollection of the incident.</p> <p>During an interview on 4/29/25 at 2:07 PM, the interim Director of Nursing stated the facility concluded that sexual abuse was founded, based on Resident #2 being witnessed touching an intimate body part of Resident #1 and statements obtained from staff. They stated Resident #2 was referred to psychiatry for an evaluation, and ultimately had a room change to a different unit.</p> <p>During an interview on 4/29/25 at 2:28 PM, Certified Nurse Aide #1 stated on 2/3/25 after dinner, they walked into the dining room and saw Resident #2 sitting close to Resident #1, then they saw Resident #2's hand moving under Resident #1's shirt. They stated Resident #1 was not wearing a bra, their breast was exposed, and they saw physical contact by Resident #2 on Resident #1's breast. They stated they told Resident #2 to stop. They removed Resident #1 from the dining room and reported what they saw immediately to their charge nurse because it was sexual abuse. They stated that Resident #2 was removed from the dining room as well and taken back to their room where they remained the rest of the shift. Additionally, Certified Nurse Aide #1 stated that Resident #1 did not seem to react to being touched.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/29/25 at 4:21 PM, Licensed Practical Nurse #1, Nursing Supervisor, stated they notified the Director of Nursing of the incident on 2/3/25 between Resident #1 and Resident #2 immediately. They stated at their job level they were only responsible for making sure the residents were separated and making sure they were safe. They stated they were not responsible to implement any new interventions. Licensed Practical Nurse #1, stated they initiated an incident report for both Resident #1 and Resident #2. They stated Resident #2 touching Resident #1's breast would be physical, sexual abuse. Resident #1 was not capable of giving consent and Resident #2 was alert, oriented, and touched Resident #1 without permission. Licensed Practical Nurse #1 stated that visual monitoring of Resident #2 was completed by the nursing staff on unit to make sure they were not around any female residents. Additionally, they stated there should have been documentation of monitoring for the safety of the victim (Resident #1) and to make sure Resident #2 did not do it again.</p> <p>During an interview on 4/30/25 at 9:21 AM, Licensed Practical Nurse #2 stated Resident #2 was returned to their room after they were separated from Resident #1 on 2/3/25 in the dining room. They stated they placed their medication cart outside Resident #2's room, to closely monitor their whereabouts. Licensed Practical Nurse #2 stated that Resident #2 remained in their room for the remainder of the shift and the night nurse was alerted to keep an extra eye out on Resident #2. Licensed Practical Nurse #2 stated Resident #2 knew what they did.</p> <p>During an interview on 5/1/25 at 1:08 PM, the Medical Director stated they would consider the touching of a residents' breast sexual abuse especially if a resident has not consented or was unable to consent. The Medical Director stated Resident #1 lacked the ability to give consent. They stated Resident #2's cognition was poor and were not aware of what they were doing all the time.</p> <p>Review of facility employee list with job description/phone numbers received upon entry on 4/29/25, documented 248 staff members.</p> <p>Review of In-Service Program Record titled Resident Abuse Reporting and Speak Up dated 2/6/25 documented 87 staff member signatures.</p> <p>During an interview on 5/1/25 at 2:16 PM, the Inservice Coordinator stated they in-serviced as many staff members as they could on 2/6/25.</p> <p>10 NYCRR 415.3(d)(1)(vii)</p>		