

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 07/22/2025
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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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: 335326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, and record review conducted during an Abbreviated survey (Complaint #NY00374712), the facility did not ensure that pharmaceutical services (including procedures that assure the accurate administering of all drugs) met the needs of each resident for one (Resident #1) of three residents reviewed. Specifically, the facility did not ensure nursing staff administered Resident #1's anticonvulsant medications within the allowed administration timeframe and/or that the medication was signed for at the time of administration. Additionally, the Medical Provider was not notified. The finding is: The policy titled Liberalized and Standardized Medication Administration Schedules dated 5/29/25 documented medications will be delivered in a manner that was least restrictive and intrusive while allowing for optimal therapeutic effect of medications. Standard time schedules are medications scheduled at a specific time by a provider and are considered timely if they are administered within one hour before or after the defined time period. The policy documented that if any reason the medication was not administered within the scheduled time limits, the nursing supervisor and medical provider would be notified. An order to administer the medication at the current time may be considered. The policy documented that time-sensitive medications are medications that have a narrow therapeutic index or medications that require specific times for clinical safety and efficacy. Resident #1 had diagnoses that included obstructive hydrocephalus (buildup of fluid in cavities within the brain), dependence on a respirator (ventilator) and epilepsy (seizures). The Minimum Data Set (a resident assessment tool) dated 6/5/25 documented Resident #1 was severely cognitively impaired, sometimes understands, sometimes understood and took anticonvulsant medications. The comprehensive care plan dated 7/5/24, documented Resident #1 had a seizure disorder with episodes of seizure activity. Interventions included to administer medications as ordered by the medical doctor or nurse practitioner, monitor and document for seizure activity and update the medical doctor or nurse practitioner on the resident's status as indicated. During an interview on 7/11/25 at 1:24 PM, Resident #1's family member stated that Resident #1 medications, at times, were administered late and, at times, up to three hours late. The family member stated, last month (unknown day) Resident #1's hallway was staffed with an agency nurse, and they were still passing their dinner medications at 9:00 PM. Review of the Order Listing Report (medical provider orders) dated 7/15/25 documented Resident #1 had the following orders:-Valproic acid 450 milligrams every six hours with start date of 1/14/25-Vimpat 100 milligrams every twelve hours from 2/13/25 until 4/21/25-Vimpat 50 milligrams every twelve hours started on 4/22/25 Review of the Medication Administration Audit Reports revealed the following: -the report dated 7/14/25 documented for 3/1/25-3/31/25, Valproic Acid 450 milligrams and Vimpat 50 milligrams were administered six times past the allowed administration time frame (1 hour before and 1 hour after the time ordered). Additionally, there were multiple days in which the medications were documented as administered two (2) or more hours late.-the report dated 7/16/25 documented for 6/1/25-6/30/25, Valproic Acid 450 milligrams was administered three times past the allowed administration time frame and Vimpat 50 milligrams was administered four times past the allowed administration time. There were at least two (2) days the medications were documented as administered two (2) or more hours late.-the report dated 7/15/25 documented for 7/1/25-7/15/25, Valproic Acid 450 milligrams was administered twice past the allowed administration time frame and Vimpat 50 milligrams was administered four times past the allowed administration time; in which at least one day it was documented as more than two hours late. Review of the progress notes dated 3/6/25-7/16/25 revealed no documented evidence that the supervisor and/or medical provider were notified when the Valproic Acid and Vimpat medications were administered outside of the allowed time frame. During a telephone interview on 7/15/25 at 12:01 PM, Medical Doctor #1 stated they would expect Resident #1's anticonvulsant medications to be given within an hour or two of the medication being ordered and any time after that would be too late. They stated Vimpat and Valproic Acid were significant medications, and it was important to administer the medication within an hour or two of it being ordered to maintain the threshold of the medication in the resident's blood stream. Medical Doctor #1 added, one does not want to administer the dosing too close together because that could cause an issue. During a telephone interview on 7/15/25 at 12:33 PM, Registered Nurse #4 stated they usually were responsible for Resident #1's care from 7:00 AM - 7:00 PM three times a week and would be responsible for the 6:00 PM medication pass. Registered Nurse #4 stated they signed off their medications in the electronic medical record at the time of administration and the time documented in the electronic medical record would be the time they administered Resident #1's anticonvulsant medications.</p>		