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 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Williamsville	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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during a survey, the facility failed to check the code status to an unresponsive resident who had a Do Not Resuscitate (DNR) Order with Advance Directives in place for one (1) (Resident #1) of three (3) residents reviewed. Specifically, Resident #1 was found unresponsive on [DATE] at 2:09 PM, without a pulse, respirations, or blood pressure by Licensed Practical Nurse #1. Licensed Practical Nurse #1 failed to check code status of Resident #1 and initiated Cardiopulmonary Resuscitation (CPR). Based on interviews and record review it was determined the facility corrected the non-compliance as of [DATE] and was cited at Past Noncompliance. The findings include: The policy and procedure titled Basic Life Support dated [DATE] documented procedures including cardiopulmonary resuscitation, rescue breathing and defibrillation will be initiated on all appropriate residents unless advanced directives documenting the exclusion of these procedures are on file in the medical record.Resident #1 had diagnoses that included dementia, depression and coronary artery disease (a heart condition where plague builds up to the arteries, reducing blood flow and oxygen to the heart). The Minimum Data Set (a resident assessment tool) dated [DATE] documented the resident was usually understood, usually understands and was moderately cognitively impaired. The resident expired at the facility on [DATE]. The Care Plan Report with a revision date of [DATE] documented the resident had Advance Directives which included a health care proxy and activated Medical Orders for Life Sustaining Treatment (MOLST) with interventions that included, resident wishes will be followed per the provider's order.The Order Listing Report dated [DATE] documented Resident #1 had a Do Not Resuscitate (DNR) status, allow nature death.The Medical Orders for Life Sustaining Treatment (MOLST) dated [DATE] documented the resident had a Do Not Resuscitate status.Provider note written by Nurse Practitioner #1 dated [DATE] documented the resident's code status was Do Not Resuscitate and Do Not Intubate on file, do not attempt resuscitation.A Progress Note written by Licensed Practical Nurse #1 dated [DATE] at 2 :55 PM documented at 2:05 PM certified nurse aide came to get writer stating the resident was on a folding chair in their bathroom, not responding. This writer immediately went to assess the resident, the supervisor was called STAT (immediately) to the unit, and writer went back down to the room to get vitals on the resident. Resident#1 had no pulse noted, they lowered the resident to ground and Cardiopulmonary Resuscitation was initiated. Upon arrival of supervisor and residents chart it was noted that the resident had a Do Not Resuscitate status. 911(emergency medical services) had already been called. Cardiopulmonary Resuscitation continued until emergency medical services arrived and ended code at 2:23 PM. A Progress Note written by Registered Nurse #1 Nursing Supervisor dated [DATE] at 3:08 PM documented this writer entered room of resident at approximately 2:10 PM. Resident was in the bathroom lying on the floor and the unit nurse (Licensed Practical Nurse #1) was performing Cardiopulmonary Resuscitation. This writer called, 911. Another nurse brought the chart into the room, and it was noted that the current Medical Orders for Life Sustaining Treatment stated Do Not Resuscitate. Right after this the Emergency Medical Service arrived, and they were updated on the current situation. The Emergency (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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NAME OF PROVIDER OR SUPPLIER Elderwood at Williamsville		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Bassett Road Williamsville, NY 14221	

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the incident.During an interview on [DATE] at 12:10 PM, Registered Nurse #1 Nursing Supervisor stated they were supervising the day Resident #1 passed away. Registered Nurse #1 Nursing Supervisor stated they arrived at Resident #1 room after being paged to the unit. They asked Licensed Practical Nurse #1 who was performing chest compressions at the time what was the code status of Resident #1 and Licensed Practical Nurse #1 stated full code. Registered Nurse #1 Nursing Supervisor assumed the resident's code status was checked. They asked Registered Nurse #3 to go and get Resident #1's medical chart. Emergency Medical Service had not arrived yet but had been called. Resident #1 was determined to have Do Not Resuscitate and Do Not Intubate status per Medical Orders for Life Sustaining Treatment. Staff continued with the code until Emergency Medical Service arrived and took over. Registered Nurse #1 Nursing Supervisor stated they were always told not to stop a code once it was started. Emergency Medical Service arrived and were informed Cardiopulmonary Resuscitation was started in error prior to checking the resident's code status. Emergency Medical Service called the EMS provider, and Cardiopulmonary Resuscitation was terminated. Resident #1 passed away. They asked Licensed Practical Nurse #1 if they checked code status prior to starting Cardiopulmonary Resuscitation and Licensed Practical Nurse #1 replied that they did not check the resident's code status. They also stated all nursing staff were re-educated after the incident.During an interview on [DATE] 1:49 PM, the Medical Doctor stated they were not involved with the incident and stated they would expect if a resident was found unresponsive to call for help, check vital signs, check the residents advanced directive status, and start Cardiopulmonary Resuscitation if need be.During an additional interview on [DATE] at 2:04 PM, the Administrator stated they would have expected Licensed Practical Nurse #1 to have checked Resident #1's code status prior to starting Cardiopulmonary Resuscitation and they did not.The following corrective actions were implemented by the facility to correct the non-compliance as of [DATE] prior to survey entrance.-The facility reported the alleged failure to follow the plan of care accordingly, and an investigation was started immediately.-Licensed Practical Nurse #1 was immediately removed from the schedule pending investigation and re-educated on basic life support policy and procedure.-The policy and procedure on Basic Life Support was reviewed with no revisions required.-Full house resident audit, census 164 was completed on [DATE] to ensure all present residents residing in the facility advanced directives were in accordance with their wishes.-Residents who passed away in the last three (3) months advanced directives were audited on [DATE] with no negative outcomes.-Code Blue drills were completed on [DATE], [DATE], [DATE] and [DATE] with no issues identified.-85 percent (%) nursing staff, were re-educated on [DATE] through [DATE] (post incident) regarding Advanced Directives and Basic Life Support.-Results of the audits will be reviewed at the next Quality Assurance meeting on [DATE]. 10 New York State Code Rules and Regulations 415.39(e)(2)(iii)