STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335346	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Waverly	37 North Chemung Street Waverly, NY 14892

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35045 Based on record review and interviews during the abbreviated survey (NY00369096), the facility failed to establish mechanisms for documenting and communicating the resident's choice regarding Advance Directives to the staff responsible for the resident's care for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 updated their Medical Orders for Life-Sustaining Treatment to reflect a change in their wishes from cardiopulmonary resuscitation (attempt to restart the heart) to do not resuscitate (allow natural death). The paper medical record (Medical Order for Life Sustaining Treatment form) and electronic medical record code status orders did not match to reflect the resident's Advance Directives wishes to allow natural death (do not resuscitate). Subsequently, when the resident was found without signs of life, nursing staff verified their status with the prior Medical Orders for Life-Sustaining Treatment form and initiated cardiopulmonary resuscitation. When nursing staff noted in the electronic record there was an order for do not resuscitate, lifesaving efforts were discontinued, and the resident was pronounced deceased . This resulted in no actual harm with likelihood of serious harm, serious injury, or serious impairment, that is Immediate Jeopardy past non-compliance, for all residents in the facility who had advance directives in place. Finding includes: The facility policy, Basic Life Support, revised [DATE], documented: - Basic life support included cardiopulmonary resuscitation, rescue breathing, and defibrillation, and would be initiated on all appropriate residents unless advance directives documenting exclusion of these procedures were on file in the medical record. - When a resident was found unresponsive, staff should immediately confirm Do Not Resuscitate status. The electronic record would be utilized as the initial method of immediate identification. Another staff should obtain the paper medical record, and this will be the confirmation method of verifying code status in all instances. - If Do Not Resuscitate status is not present and immediate response was critical. Call 911, announce Code Blue, position resident on back board, check pulse and breathing, and begin cardiopulmonary resuscitation once Code status was confirmed. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335346	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Waverly	37 North Chemung Street Waverly, NY 14892

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 had diagnoses including acute posthemorrhagic anemia (condition that occurs when a significant amount of blood is lost), pancytopenia (blood disorder that occurs when the bone marrow has issues forming all three types of blood cells), and chronic kidney disease. The [DATE] Brief Interview for Mental Status assessment documented the resident's cognition was intact. The [DATE] Comprehensive Care Plan documented the resident's Advance Directive was full code (initiate lifesaving interventions). Interventions included the advance directive documentation should be reviewed quarterly and as needed. The [DATE] physician order documented Full Code. The Medical Orders for Life Sustaining Treatment form, signed by the resident on [DATE] at 1:30 PM, documented the resident wished for a cardiopulmonary resuscitation order in the event their heart stopped. The [DATE] at 3:46 PM Registered Nurse Unit Manager #2 progress note documented the resident arrived back to facility (from the hospital) and was able to make their needs known. The Medical Orders for Life Sustaining Treatment form was reviewed with the resident and a family member/ healthcare proxy and was signed and updated. The Medical Orders for Life Sustaining Treatment form, signed by the resident's healthcare proxy on [DATE] at 3:00 PM, documented the resident wished for a do not resuscitate order. The form was witnessed by Registered Nurse Unit Manager #2 and Licensed Practical Nurse #4. The form was signed by Nurse Practitioner #5 on [DATE]. The [DATE] electronic medical record order, entered by Registered Nurse Unit Manager #2 documented Do Not Resuscitate. There was no documented evidence the [DATE] Medical Orders for Life Sustaining Treatment was voided when a new Medical Orders for Life Sustaining Treatment was completed. The [DATE] Physician #9 progress note documented the resident was cognitively intact, had been readmitted to the facility on [DATE] after a hospitalization and based on diagnosis of myelodysplastic syndrome (a blood disorder) and declination of bone marrow biopsy, the resident opted for comfort care measures. The facility investigation dated [DATE], documented: - the resident returned from the hospital on [DATE] and Registered Nurse Unit Manager #2 met with the resident and family. They completed a new Medical Orders for Life Sustaining Treatment form and changed the code status from full code to Do Not Resuscitate. The new form was signed and placed on the medical provider's clipboard for review. The Do Not Resuscitate order was placed in the electronic record. - The prior Medical Orders for Life Sustaining Treatment form was not voided and remained in the file on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335346	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Waverly	37 North Chemung Street Waverly, NY 14892

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE] at 4:22 AM, the resident was found unresponsive and not breathing in their room by Certified Nurse Aides #10 and #11. The aides called for assistance; Licensed Practical Nurse #12 and Registered Nurse Supervisor #3 immediately responded, and a Code Blue was paged. - On [DATE] at 4:23 AM, the Medical Orders for Life Sustaining Treatment form was pulled from the file (hard copy on the unit) and the resident was determined to be full code status. Registered Nurse Supervisor #3 started chest compressions. - On [DATE] at 4:34 AM, Emergency Medical Services arrived and took over compressions. - On [DATE] at 4:44 AM, Registered Nurse Supervisor #3 left the room to call the family and notified the on-call Administrator and Assistant Director of Nursing. They were not able to reach the family. - On [DATE] at 4:48 AM, while speaking with the resident's relative, Registered Nurse Supervisor #3 noted in the electronic record the resident had an order for Do Not Resuscitate. The resident's relative/ healthcare proxy confirmed the resident's wishes were Do Not Resuscitate. - On [DATE] at 4:51 AM, Registered Nurse Supervisor #3 notified Licensed Practical Nurse #12 that the family stated the resident was a Do Not Resuscitate. The Director of Nursing was made aware of the situation and Licensed Practical Nurse #12 was looking for the Medical Orders for Life Sustaining Treatment form that was completed on [DATE] - On [DATE] at 4:54 AM, Licensed Practical Nurse #12 found the new form on the provider clipboard and notified Registered Nurse Supervisor #3. - On [DATE] at 4:55 AM, Registered Nurse Supervisor #3 brought the new Medical Orders for Life Sustaining Treatment form dated [DATE] to the room and notified Emergency Medical Services the resident's wishes were Do Not Resuscitate. - On [DATE] at 4:56 AM, all life support efforts were stopped. During an interview on [DATE] at 1:56 PM, Registered Nurse Supervisor #3 stated they were the supervisor on call on [DATE] when the staff notified them Resident #1 was unresponsive. They assessed the resident, who had no pulse. They told the staff to get the crash cart and pull the Medical Orders for Life Sustaining Treatment form. One of the certified nurse aides told Registered Nurse Supervisor #3 Resident #1 was a full code. They reviewed the Medical Order for Life Sustaining Treatment dated [DATE]. During the code, Registered Nurse Supervisor #3 left the room to call the family, and an aide stated the resident had a do not resuscitate order in the electronic record. When the Registered Nurse Supervisor was on the phone with the family member, the family member confirmed the resident had a new order for Do Not Resuscitate. Registered Nurse Supervisor #3 stated they were taught to pull the Medical Orders for Life Sustaining Treatment form from the file, but the updated Medical Orders for Life Sustaining Treatment form was on the provider desk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335346	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Waverly	37 North Chemung Street Waverly, NY 14892

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:34 AM, the Director of Nursing/Administrator on Record stated after the incident on [DATE], it was determined their system broke down when the new Medical Orders for Life Sustaining Treatment form for Resident #1 was completed on [DATE]. The form was placed on a hanging clipboard for the providers to review and not in the file. When a resident was unresponsive, they should first confirm their code status/order by looking in the electronic medical record. This information would show on the top of the screen under the special instructions for the resident. They stated it was important to have an accurate order and Medical Orders for Life Sustaining Treatment form to ensure the healthcare staff know what the resident wishes were if they were unable to speak in an emergency. During an interview on [DATE] at 9:57 AM, Registered Nurse Unit Manager #2 stated Resident #1 had returned from the hospital and stated they wanted to change their code status and update their Medical Orders for Life Sustaining Treatment form to a Do Not Resuscitate status from full code. The form was completed and put on the provider clipboard and the new order was put in the electronic medical record. They were not sure where to put the new form and did not know they should have placed it in the file with the old form. They put it on the provider clipboard so the provider could sign the new form. During an additional interview at 3:47 PM, they stated they reviewed the hospital discharge summary on [DATE] that stated the resident wanted to be placed on comfort measures. They had to call the on-call provider, Physician #9, to notify them of the changes and then put the verbal order in the electronic record. The resident had capacity to make their own decisions, and the form was changed after discussion with Resident #1 and their family member present. During a telephone interview on [DATE] at 10:45 AM, Nurse Practitioner #5 stated they were unable to recall when they signed Resident #1's updated Medical Orders for Life Sustaining Treatment form. Each unit had a file system and when a Medical Order for Life Sustaining Treatment form needed to be updated, the staff would write a note on the provider clipboard and place the form vertical in the file to prompt the providers to review and sign. It was important to have these forms updated so the healthcare team and family knew what medical measure to take for the resident in case of an emergency or tragic event. During a telephone interview on [DATE] at 1:08 PM, the Medical Director stated the purpose of an accurately completed Medical Orders for Life Sustaining Treatment form was to outline the goal of care for the resident, and to make clear their wishes in certain medical situations. When a resident updated their Medical Orders for Life Sustaining Treatment, the order should be updated in the electronic record, and a Registered Nurse can take the order and put the code status in the record. They stated they have had some recent staffing changes, and the staff should not have placed updated or new Medical Orders for Life Sustaining Treatment form on the provider clipboard; it should have been placed in the file for Medical Orders for Life Sustaining Treatment forms. 10NYCRR 400.21(c) _____ Immediate Jeopardy past non-compliance was identified, and the Administrator on Record was notified on [DATE] at 5:57 PM. The facility provided verification the following corrective actions were completed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335346	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Waverly	37 North Chemung Street Waverly, NY 14892

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE], the system for filing the forms was revised. The Medical Orders for Life Sustaining Treatment forms were to be completed upon admission and readmission to ensure accurate code status. Once the new Medical Orders for Life Sustaining Treatment form was completed, it was to be placed in the file and the old form would be marked on the last page. form changed, new form completed. The reviewer would enter the date and time, then sign. Once completed, the voided form would be filed in medical record. The new Medical Orders for Life Sustaining Treatment form was to remain in the file on the unit (not the medical provider clipboard). - On [DATE], all licensed nursing staff were educated on the process for completing a new Medical Orders for Life Sustaining Treatment form, and identification and verification of advance directives. The electronic record would be verified initially and then the paper medical record would be used to confirm the status; this record would be brought to the room where basic life support was being considered. - On [DATE], a full house audit was completed to verify all Medical Orders for Life Sustaining Treatment forms were signed and executed, and that orders were entered correctly into the electronic medical record. - On [DATE], the facility initiated five audits per week for three months to ensure staff could verbalize the appropriate measures and how to verify code status when they found an unresponsive resident. - On [DATE], all staff responsible for performing cardiopulmonary resuscitation or verifying Medical Orders for Life Sustaining Treatment forms were re-educated by the Director of Nursing and Educator on the facility policy for Basic Life Support and the new process for filing the Medical Orders for Life Sustaining Treatment forms. - The facility will complete audits for six months (ending [DATE]) for any resident who expired at the facility to ensure that the policy for Basic Life Support and Medical Orders for Life Sustaining Treatment orders were honored. Any deficiency will be reported to the Director of Nursing immediately. - The facility planned to conduct one code drill per shift for one month, and then quarterly thereafter, to monitor compliance. - Medical Orders for Life Sustaining Treatment audits would be completed by the social workers weekly, for eight weeks and then monthly for three months. All results of the audits were to be reported to the Quality Assurance Team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335346	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Waverly	37 North Chemung Street Waverly, NY 14892

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 37385 Based on observations, record review, and interviews during the abbreviated survey (NY00369577), the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 3 residents (Resident #2) reviewed. Specifically, Resident #2 did not receive assistance at meals as care planned. Findings include: The facility policy, Activities of Daily Living Assistance and Supervision, revised 1/4/2018 documented the Unit Manager/designee would ensure that a plan of care for receiving activities of daily living assistance and/or supervision was incorporated into the daily nursing care of each resident. Resident #2 had diagnoses including Alzheimer disease and self-feeding difficulties. The 11/28/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, did not reject care, required partial/moderate assistance with eating, and received a mechanically altered diet. The Comprehensive Care Plan updated on 12/5/2024 documented the resident had an activity of daily living self-care performance deficit and impaired physical mobility related to muscle weakness. Interventions included to provide partial or moderate assistance, one-person physical assistance with eating. The 8/27/2024 physician orders documented comfort measures only, no weights, no tube feeding, and no intravenous fluids. The Comprehensive Care Plan and care instructions updated on 12/5/2024 documented the resident had a potential for alteration in nutrition related to Alzheimer's disease and dementia. Interventions included to provide adaptive equipment at meals, monitor and record intake of solids and fluids, monitor for signs of dehydration/malnutrition, provide half portions of regular puree solids and thin liquids, meals in the dining room, offer 120-240 milliliters of fluids between meals three times daily, and provide 120 milliliters Mighty Shake (oral nutrition supplement) at meals. The resident's food was to be in bowls, staff was to place 1 drink in front of the resident at a time to encourage intake of food items, load utensil, tap the resident's right hand to initiate feeding, and check oral cavity at the end of the meal for possible pocketing of food. The following observations of the resident were made: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335346	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Waverly	37 North Chemung Street Waverly, NY 14892

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 1/29/2025 at 9:05 AM seated in the dining room at a table for breakfast. Their meal included 4-ounce nutrition shake, 8 ounces whole milk, pureed potatoes in a bowl, pureed toast in a bowl, and pureed egg and ham in a bowl. Their food items were all in front of the resident. There were 2 nosey cups (adaptive cup) and 1 large maroon spoon. Their meal ticket documented partial to moderate assistance. The resident was drinking from their nosey cup independently. At 9:18 AM, the resident was independently eating their pureed toast. At 9:20 AM, Certified Nurse Aide #2 asked the resident if they wanted any condiments on their pureed eggs and told the resident what food items were in front of them. The resident continued to eat slowly and did not receive staff assistance or encouragement. At 9:32 AM, certified nurse aide asked the resident if they were done with their meal and removed the meal tray. The resident had consumed 100% of their milk and Mighty Shake (oral nutrition supplement), 75-100% of their pureed toast, 0-25% of their pureed egg and ham, and 0-25% of their pureed potatoes. - on 1/29/2025 at 12:18 PM, in the dining room seated at a table for lunch. All their meal items and drinks were in front of them. The resident had 4 ounces of nutritional shake, an 8 ounce unopened container of whole milk, 1 bowl of pureed beets with the lid on it, 1 bowl of puree potatoes, 1 bowl of pureed meatloaf, and 1 bowl of applesauce. The resident was drinking their nutrition supplement independently. At 12:25 PM, the resident was observed using their large maroon spoon to take spoonfuls of mashed potatoes by themself. At 12:27 PM, Certified Nurse Aide #2 walked over to the resident and spoke to them and left. The aide continued to circulate in the dining room without assisting the resident. From 12:45 PM -12:58 PM, the resident continued to eat slowly and was not assisted or encouraged by staff. At 1:02 PM, Certified Nurse Aide #1 asked the resident if they were done and removed their meal tray. The resident had consumed 100% of their oral nutrition supplement, 0-25% of applesauce, 25-50% pureed mashed potatoes, and 0-25% of their pureed meatloaf. Their 8 ounces of whole milk remained unopened, and the lid remained on the bowl of beets. During an interview on 1/29/2025 at 1:08 AM, Certified Nurse Aide #1 stated staff knew what level of assistance to provide residents by looking at their care plans and it was also listed on the meal ticket. They stated they were assigned to help in the dining room during the lunch meal. Resident #2 did not eat well and drank better at meals. Their intakes were usually 25-50% at meals. They did not know what level of assistance the resident required at meals and checked their care plan. They stated the resident's care plan indicated they were to receive partial to moderate assistance of 1 at meals and the resident did not receive their care planned assistance at the lunch meal. They stated staff that were assigned to the dining room should be checking the resident's meal tickets and care plans to ensure they received the assistance required. If a resident did not receive the level of assistance as care planned it could impact their nutritional status. During an interview on 1/29/2025 at 1:36 PM, Certified Nurse Aide #2 stated they were assigned to the dining room at breakfast that day. They stated staff knew what level of assistance to provide residents by looking at their care plans and it was also listed on the meal ticket. They stated partial/ moderate assistance meant the resident required verbal and sometimes physical cues. If a resident did not receive their care planned level of assistance at meals it could impact the resident's intakes and possibly weights. They stated Resident #2 drank better than they ate. Their intakes were usually 25-50% at meals and very seldom completed all their meals. They were unsure of the resident's level of assistance required at meals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335346	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Waverly	37 North Chemung Street Waverly, NY 14892

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/2025 at 2:24 PM the Director of Therapy stated Occupational Therapy determined the level of assistance a resident needed at meals. Partial to moderate assistance with eating meant staff should provide physical and verbal cues to encourage mealtime intakes. Resident #2 required partial moderate assistance of 1 with meals. During an interview on 1/29/2025 at 3:02 PM Registered Nurse Unit Manager #3 stated they expected staff to open all food items for the residents at meals and assist as care planned. If they had any questions, they should check the resident's care plan or ask the nurse. If a resident did not receive their care planned level of assistance at meals it could impact their nutritional status. 10NYCRR 415.12(a)(3)