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	03/28/2025

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. 48052 Based on observations, record review, and interviews during the recertification survey conducted 3/24/2025 to 3/28/2025, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition for 1 of 7 residents (Resident #142) reviewed. Specifically, Resident #142 was not provided with supervision and maximum cueing with eating and was not provided meals in the dining room as planned. Findings include: The facility policy [Activities of Daily Living] Assistance and Supervision. approved 1/18/2018, documented the Unit Manager and licensed practical nurse team leaders monitored the activity of daily living and supervision provided to the residents and gave appropriate guidance and assistance to nursing staff. The certified nurse aides provided the activities of daily living assistance and supervision to their assigned residents. The personal care profile and care plan were referenced for the type of activities of daily living and supervision needed by a resident. Resident #142 had diagnoses including Parkinson's disease (a progressive neurological disorder), dysphagia (difficulty swallowing), and dementia. The 2/19/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, had no behavioral symptoms, and required supervision/touching assistance for eating. The Comprehensive Care Plan, initiated 7/24/2023 and revised 3/7/2025, documented the resident had an activities of daily living function and mobility deficits related to muscular weakness. Interventions included the resident required supervision or touching assistance for eating, was to be in the dining room for all meals and needed maximum encouragement for eating. The resident had an eating functional maintenance plan to have the staff set-up the resident's meals, strongly encourage the resident to eat in the dining room for all meals and required supervision to stand by assistance and constant verbal cues to eat and not just drink at meals. Turn off the television when providing care in the resident's room to increase participation as they were easily distracted and had increased difficulty participating in activities of daily living when their attention was divided. The resident's care instructions (Kardex) documented the resident required supervision or touching assistance and maximum encouragement at meals and was to be in the dining room for all meals. The percentage of meal consumption from 03/20/2025 to 3/27/2025 documented: (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	03/28/2025

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 3/20/2025 breakfast was 26-50%, lunch was not documented; and dinner was 0-25%; - on 3/21/2025 breakfast was 0-25%, lunch was 0-25%, and dinner was 0-25%; - on 3/22/2025 breakfast was 0-25%, lunch was 26-50%, and dinner 51-75%; - on 3/23/2025 breakfast was 0-25%, lunch was 0-25%, and dinner was 26-50%; - on 3/24/2025 breakfast was refused, lunch was 0-25%, and dinner was 51-75%; - on 3/25/2025 breakfast was 51-75%, lunch was 0-25%, and dinner 0-25%; - on 3/26/2025 breakfast was 26-50%, lunch was 0-25%, and dinner 0-25%; - on 3/27/2025 breakfast 0-25%, and lunch 0-25%. The following observations of Resident #142 were made: - on 3/24/2025 at 12:02 PM staring straight ahead and not eating their lunch. There was no staff encouragement provided to the resident throughout the meal. - on 3/26/2025 at 11:36 AM, Licensed Practical Nurse #20 asked the resident if they wanted to have lunch in the common area across from the nursing station and the resident agreed. At 12:17 PM, the resident had their meal on an overbed table. There was a partially eaten hot dog in their hand, resting on their leg. At 12:26 PM, the resident continued to hold the hot dog in their hand, resting on their leg. The resident was staring straight ahead. The rest of their meal tray included meat loaf, cheesy potatoes, beets, chocolate milkshake, and pears and was untouched. Staff did not provide encouragement or assist the resident with their meal. - on 3/27/2025 at 8:59 AM in bed with their breakfast tray in front of them on the overbed table. The tray included two juices, chocolate milk, eggs, biscuits and gravy, and a cut up banana. All the items appeared untouched. The resident was watching television. Licensed Practical Nurse #34 administered the resident's morning medications and did not encourage the resident to eat or offer food alternatives. From 11:56 AM to 12:58 PM, the resident was in the dining room and received their lunch tray which included a hotdog with mustard, a small portion of turkey noodle bake, and bacon brussels sprouts. The resident did not eat anything on their tray. At 12:30 PM Certified Nurse Aide #42 passed by the resident without stopping and encouraged them to eat their hotdog. The resident only drank their chocolate milk and was not offered an alternative when they did not eat their lunch. - on 3/28/2025 at 8:58 AM sitting on the side of their bed looking out window. The resident had untouched toast with jam and two pieces of bacon on their breakfast tray. The resident drank all their chocolate milk and some of their juice. At 9:17 AM, the resident had not touched their meal. (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	03/28/2025

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 3/28/2025 at 9:34 AM, Certified Nurse Aide #33 stated a resident's meal assistance level was on the resident care instructions. If a resident required supervision with max cueing that meant staff had to constantly encourage the resident to pick up a utensil and put it to their mouth. Resident #142 required supervision with max cueing for their meals. The resident was provided cueing for lunch but not as much during breakfast. They stated they were not present for lunch on 3/27/2025 so they did not know if the resident was cued. It was important to provide cueing and supervision so the resident could get proper nutrition. During an interview on 3/28/2025 at 9:58 AM, Licensed Practical Nurse #34 stated the resident care instructions documented a resident's assistance level for meals. Resident #142 required supervision for meals. Supervision with max cueing meant the resident had to be reminded to take a bite, take a drink, and have someone always supervising. They expected Resident #142 to be supervised and receive max cueing with meals. If the resident was alone in their room or in the independent dining room with no one cueing them, they were not receiving supervision with max cueing as planned. During an interview on 3/28/2025 at 10:21 AM, Registered Nurse Unit Manager #19 stated resident care instructions documented what the resident's assistance level was for meals. Resident #142 required supervision with max cueing for meals which meant staff went in and out to supervise and offer food to the resident. They expected the resident receive assistance during meals as care planned. If the resident was in the independent dining room they should receive cueing during meals. It was important to provide cueing and supervision, so they received proper nutrition. During an interview on 3/28/2025 at 12:25 PM, the Assistant Director of Therapy/Occupational Therapist #31 stated Resident #142's functional maintenance program was initiated in January 2024 and updated in March of 2024. Resident #142 required supervision with maximum cueing due to the resident having trouble maintaining attention when eating. The resident consumed liquids but did not eat when unattended. This did not mean someone had to sit with Resident #142 constantly during their meal, but they should be giving the resident consistent cues to eat if they were not paying attention. If Resident #142 was in their room during breakfast, the cueing would be more intermittent. If the resident was in the dining room and had not touched their food, staff should provide more frequent cueing. They stated if the resident did not touch their food and was not provided with cueing, that was a problem. If a resident needed cueing and did not receive it, they could have decreased intake and weight loss. 10 NYCRR 415.12(a)(3)

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	03/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40803 Based on observations, record review, and interviews during the recertification and abbreviated (NY00333993) surveys conducted 3/24/2025-3/28/2025, the facility did not ensure residents received adequate supervision to prevent accidents for 2 of 13 residents (Residents #164, and #171) reviewed. Specifically, -Resident #171 had dysphagia (difficulty swallowing), was on aspiration (inhaling food/fluid into the lungs) precautions and the resident was provided ice chips without a physician order or supervision. -Resident #164 was at high risk for elopement (leaving premises/safe area without facility knowledge), the resident frequently wandered in non-residential areas, and there was no documented evidence of a plan to limit the resident's wandering to potentially unsafe areas. Additionally, the resident's wander alert device was not checked for function as planned. Findings include: The facility policy Aspiration Precautions Guidelines, revised 7/24/2018 documented if orally fed, maintain the resident's head of bed at 45 or higher for at least 30 minutes after meals and consumption of food/liquids, unless otherwise ordered by medical. Provide constant supervision/assistance at mealtime. Observe closely for signs/symptoms of aspiration (respiratory distress, coughing, wheezing, cyanosis [bluish discoloration from low oxygen levels], and tachycardia [high heart rate]). The facility policy Care Planning, revised 1/22/2019 documented the interdisciplinary team would develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. The facility policy Electronic Wandering Security System, revised 2/13/2019 documented an electronic security system designed specifically for those residents identified as being at risk for elopement was installed to allow residents to ambulate independently in a controlled, safe environment, while preventing them from leaving the building without staff awareness. The nursing staff applied and maintained the bracelet/anklet, the nurse would verify the placement of the bracelet/anklet every shift, and the nursing department or maintenance department would be designated to check the functionality of the device daily using the designated tester. Functionality would be documented in the resident medical record or maintained in the maintenance department. 1) Resident #171 had diagnoses including dysphagia (difficulty swallowing), dysarthria (slurred speech), and facial weakness following a stroke. The 2/15/2025 Minimum Data Set assessment documented the resident was cognitively intact, complained of difficulty or pain with swallowing, had a feeding tube, and received partial/moderate assistance with most activities of daily living. (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	03/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/18/2025 at 12:23 PM Licensed Practical Nurse #30 progress note documented the resident returned from a barium swallow study. Findings included aspiration of thin and nectar thick barium, penetration of honey and pudding puree barium. Recommendations included baseline diet intake (FOIS level 1, Functional Oral Intake Scale, nothing by mouth) and [NAME] free water protocol (allows patients to drink small sips of water or have ice chips between feedings). The 3/18/2025 at 1:55 PM Speech Language Pathologist #32 progress note documented the resident would remain nothing by mouth at that time and would work towards treatment for safe oral intake of purees and manage chronic pharyngeal residue. The plan did not include provision of ice chips. The 3/20/2025 at 10:35 AM Speech Language Pathologist #32 progress note documented the resident's diet changed to nothing by mouth with oral gratification to allow pureed items. The resident remained dependent on their tube feedings for nutrition and hydration. The resident was to be upright in a chair to consume by mouth and aspiration precautions were in place. The 3/20/2025 physician order documented nothing by mouth with oral gratification diet, pureed consistency, no liquids consistency; aspiration precautions maintain every shift. The Comprehensive Care Plan initiated 2/12/2025 and revised 3/20/2025 documented the resident had a potential for alteration in nutrition related to nothing by mouth status with oral gratification to allow pureed items. Interventions included aspiration precautions, pureed solids/honey thick liquids, must be out of bed and in a chair for meals, and may have 60 milliliters of ice chips upon request when upright in a chair and not in bed outside of mealtimes. The undated care instructions documented the resident was on aspiration precautions, could have 60 milliliters of ice chips with a teaspoon when upright in a chair, not in bed, and outside of mealtimes. There was no documented evidence the resident had a physician order to consume water or ice chips. The 3/24/2025 at 11:16 Physician #47 progress note documented the resident was evaluated for history of dysphagia. The resident continued to aspirate despite therapy, worse with thin liquids than with honey thickened liquids. Resident #171 was observed: - on 3/26/2025 at 10:12 AM, lying in bed with the head of bed elevated at 45 degrees. They had a 20-ounce cup full of ice chips on their bedside table and no staff was present. They stated they ate them in bed when their mouth was dry, or they were thirsty. - on 3/27/2025 at 9:00 AM, lying in bed with the head of their bed elevated at 45 degrees. Certified Nurse Aide #25 brought in a 20-ounce cup full of ice chips and put them on their bedside table and exited the room. At 9:05 AM, lying in bed with the head of their bed elevated at 45 degrees eating ice chips with a spoon. - on 3/28/2025 at 9:30 AM, lying in bed with a 20-ounce cup of ice chips on their bedside table with no staff present. (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	03/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/2025 at 1:20 PM, Certified Nurse Aide #25 stated they cared for Resident #171 that morning and brought them ice chips. They did not follow the care instructions, the resident was in bed and not in a chair, and they brought more than 60 milliliters of ice chips. They stated if they ate the ice chips in bed and not in a chair it put the resident at risk to choke, and it was important to follow the care instructions for Resident #171's safety. During an interview on 3/28/2025 at 9:48 AM, Certified Nurse Aide #29 stated Resident #171's diet recently changed, and they were allowed to have 1 pureed item at mealtime and ice chips upon request. Their care instructions said 60 milliliters of ice chips which was a small amount, and they had given the resident 20-ounces which was much more than that. They let Resident #171 have the ice chips while they were lying in bed because they thought the resident knew to sit up while eating them. They did not think the resident was on aspiration precautions. They should have the resident go to the dining room to be monitored while eating and would not have left the ice chips at their bedside without supervision. During an interview on 3/28/2025 at 10:14 AM, Licensed Practical Nurse #30 stated Resident #171's diet had recently changed, and they were allowed to have ice chips. They did not think there was a restriction on how much they could eat, and they were not aware it said 60 milliliters. The black cup at the resident's bedside was much more than 60 milliliters and the certified nurse aides should follow the care instructions for Resident #171's safety. If they left the ice chips while the resident was lying in bed and not in the chair it put them at risk for aspiration. During an interview on 3/28/2025 at 10:38 AM, Assistant Director of Therapy #31 stated Speech Language Pathologist #33 was working with Resident #171 and upgraded their diet to allow them to have 1 or 2 pureed items at mealtime and 60 milliliters of ice chips in between mealtime but they had to be out of bed and sitting in a chair. They were on aspiration precautions which meant they were supposed to have staff supervision while consuming their food or ice chips. They expected nursing to follow the recommendations they were all educated on and only give the resident 60 milliliters of ice chips at a time and not fill a 20-ounce cup and leave it at Resident #171's bedside. The resident should have a small amount of ice chips at a time with staff supervision and if they consumed them while lying in bed it put them at a higher risk for aspiration. During an interview on 3/28/2025 at 1:51 PM, Registered Nurse #14 stated the care instructions contained all the information the certified nurse aides needed to provide care and they should review them often to see if any changes were made. Resident #171 was on aspiration precautions which meant they required staff supervision while they consumed food or ice chips. The certified nurse aides were educated to know the size of their cups and 60 milliliters which was about 2 ounces of ice chips and would have been one of their medium sized plastic cup. Resident #171 should not have received a 20-ounce cup of ice chips while they were lying in bed and without direct supervision because it put them at a higher risk for aspiration or choking. Speech Language Pathologist #33 declined an interview prior to the survey exit. (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	03/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #164 had diagnoses including early onset Alzheimer's disease and history of falling. The 12/20/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, wandered 4-6 days placing the resident at a significant risk of getting to a potentially dangerous place, had no upper or lower extremity impairments, did not use a mobility device, required supervision/ touching assistance with walking 10 feet, walking 50 feet with two turns, and walking 150 feet, and used a wander/elopement alarm daily. The 12/12/2024 Elopement Assessment completed by Licensed Practical Nurse Unit Manager #5 documented the resident was a low risk for elopement. Nursing progress notes documented: - on 12/12/2024 at 10:16 PM by Licensed Practical Nurse #15 the resident was wandering the unit on several occasions. - on 12/13/2024 at 2:40 PM by Licensed Practical Nurse #9 the resident wandered down towards the lobby and was redirected by staff. - on 12/13/2024 at 2:50 PM by Registered Nurse #14 the resident was noted to have impaired cognition, wandered off the unit to the lobby, and was easily redirected. A new Elopement Assessment was completed, the resident was a high risk for elopement, and a wander alert device was applied to the resident's right ankle. The 12/13/2024 at 2:48 PM Elopement Assessment completed by Registered Nurse #14 documented the resident was high risk for elopement. The 12/13/2024 physician order documented to check for the presence of the electronic security bracelet/ anklet (wander alert device) every shift and check the function every night shift. On 12/13/2024 the Comprehensive Care Plan was updated and documented the resident was at high risk for unsafe wandering/ elopement. The resident ambulated without a device, had dementia, a history of wandering, and impaired cognition and memory. Interventions included a wander alert device on the right ankle, complete wandering/ elopement risk assessment per policy, and place a picture of the resident with the receptionist and other units as appropriate. The 12/2024 Treatment Administration Record documented check electronic security bracelet/ anklet function every night shift. Nursing progress notes by Licensed Practical Nurse #12 documented on 12/13/2024 at 11:02 PM, 12/16/2024 at 11:53 PM, 12/21/2024 at 11:15 PM, 12/22/2024 at 11:13 PM, 12/23/2024 at 10:47 PM, 12/26/2024 at 10:52 PM, and 12/30/2024 at 10:49 PM there was no meter to check the function of the resident's wander alert device. (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	03/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/14/2024 at 5:01 PM, Licensed Practical Nurse #9 progress note documented a certified nurse aide (unidentified) and they were able to redirect the resident out of another resident's rooms. The resident then walked down the hallway towards the education room and the North Unit. The resident was redirected back to their unit and the doors to the education room and North Unit were closed. At 5:22 PM, the resident wandered into the lobby and was easily directed back to the unit. The doors leading to the lobby were closed to prevent the resident from wandering off the unit. Licensed Practical Nurse #9's 12/15/2025 progress notes documented at 12:10 PM, the resident was wandering on and off the unit. The certified nurse aide (unidentified) directed the resident back from the elevators. The resident appeared agitated and was going in and out of other resident's rooms. At 1:49 PM, the resident wandered down to the time clock and was difficult to redirect. At 1:52 PM and 4:40 PM, the resident was wandering at times and was difficult to redirect. Licensed Practical Nurse #9's 12/28/2024 progress notes documented at 10:32 AM the resident was brought back to the unit from the Human Resource office area and the double doors were closed. At 11:44 AM, the resident wandered off the unit into the employee cafeteria through the kitchen entrance. The supervisor was able to redirect the resident to the lobby area and eventually back to the unit. At 5:11 PM, the resident wandered off the unit into the lobby and was brought back to the unit. There was no documented evidence the resident's care plan was revised to include interventions when the resident attempted to wander to potentially unsafe areas of the facility. Nursing progress notes by Licensed Practical Nurse #12 documented on 1/1/2025 at 11:17 PM, 1/3/2025 at 10:51 PM, 1/4/2025 at 10:55 PM, 1/5/25 at 11:59 PM, 1/6/25 at 10:42 PM, and 1/7/25 at 11:45 PM there was no meter to check the function of the resident's wander alert device. A 1/5/2025 at 12:20 PM, Licensed Practical Nurse #17 behavior monitoring note documented the resident was pacing periodically, wandering into inappropriate areas, was exit seeking, and restless. This behavior lasted over 60 minutes and non-pharmacological interventions such as toileting, offering food/ drink, and small group activities did not change their behavior. Licensed Practical Nurse #9 progress notes documented: - on 1/10/2025 at 5:41 PM the resident wandered into the lobby and other resident rooms all day. - on 1/11/2025 at 3:58 PM the resident wandered in and out of rooms. - on 1/16/2025 at 5:09 PM the resident wandered off the unit into the kitchen and was brought back to the unit by staff. A 1/17/2025 at 5:03 AM progress note by Registered Nurse #1 documented the resident wandered all night, was found in other resident's room, and in the lobby by the front door. The resident was easily redirected. A 1/22/2025 at 2:49 PM, Licensed Practical Nurse #20 behavior monitoring note documented the resident was wandering into inappropriate places, wandered off the unit into the lobby, and had increased confusion. Their behavior occurred a few times and non-pharmacological interventions were effective. (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	03/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/2025 at 4:25 PM, Licensed Practical Nurse #11 documented the resident was walked to the unit by kitchen staff who stated the resident was standing next to the steam table. The resident was currently seated in a chair by the nurse's station and would continue to be monitored. During an observation on 3/28/2025 at 10:37 AM, the employee time clock was in a hallway behind the main elevator bank near an alcove that went to the employee cafeteria, an entrance to the main kitchen with access to the steam tables, and an area where the meal carts were stored. The employee cafeteria had another entrance that accessed the hallway near the Human Resource office area. The doors to the employee cafeteria and main kitchen were open. The resident was observed on 3/27/2025 at 10:10 AM, walking the long hallway holding a doll. At 10:20 AM, wandering into other resident's rooms in the long hallway, and at 1:26 PM, walking the long hallway. During an interview on 3/28/2025 at 12:18 PM, Licensed Practical Nurse #11 stated the wander alert devices only alarmed if a resident was near the main entrance or near the Human Resource office area as there was an exit near that area to the adult day program. They did not think the system would alarm if a resident went into the main kitchen, employee cafeteria area, or time clock area. Nursing was supposed to check for the presence and function of the wander alert device. If they did not have a scanner/ meter to test the function of the wander alert device a supervisor should have been made aware. The meter was observed in the top drawer of the medication cart. They stated one evening an unknown kitchen staff brought the resident back to the unit. The resident was found by the steam tables in the serving area of the main kitchen. They alerted the Nursing Supervisor and documented the incident. During an interview on 3/28/2025 at 12:35 PM, Licensed Practical Nurse #9 stated Resident #164 used to wander the unit, go to the lobby, was found by the time clock, in the kitchen, employee cafeteria, and Human Resource office area. They alerted the nursing supervisor each time the resident was brought back to the unit from nonresidential areas and documented the incidents in their notes. They would do a visual check and document any observed issues. Nursing staff should observe the placement and test the function of the wander alert device daily, and document in the chart. If staff were unable to find the wander alert device scanner/ meter to check the function of the wander alert device, they should alert a supervisor. They never heard of any issues with the wander alert device meter missing or not working. A telephone interview was attempted with Licensed Practical Nurse #12 on 3/28/2025 at 3:21 PM and a voicemail was left. No return call was received prior to exit. During an interview on 3/282/2025 at 3:24 PM, Licensed Practical Nurse Unit Manger #5 stated wander alert devices should be checked daily for placement and function. If a nurse was unable to locate the wander alert device scanner/ meter to perform the function test they should alert the supervisor. During an interview on 3/28/2025 at 4:35 PM, the Director of Nursing stated each unit had a wander alert device scanner/ meter to check the function of wander alert devices. If they were unable to locate the wander alert device scanner/ meter they should alert the supervisor. They were unaware Resident #164 was found in the main kitchen near the steam tables and stated a supervisor should have been made aware and completed a nursing assessment. (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	03/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.12 (h) 48052 48675

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	03/28/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 48052 Based on observations, record review, and interviews during the recertification and abbreviated (NY00343302 and NY00370767) surveys conducted 3/24/2025-3/28/2025 the facility did not ensure a resident who displayed or was diagnosed with dementia, received the appropriate treatment and services to maintain their highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Residents #143) reviewed. Specifically, Resident #143's telepsychiatry recommendations for non-pharmacological interventions for behavioral symptoms were not implemented. Findings include: The facility policy SEASONS Memory Care Program, updated 12/20/2019, documented the program provided the residents a safe environment while enlarging their life with appropriate and purposeful activity that accommodated the individual's strengths, interests, and needs while promoting autonomy and assisting them in maintaining their level of ability. This was to reduce anxiety and boredom driven behaviors. The facility policy Behavior Monitoring, approved 2/10/2020, documented the facility ensured that mood, behaviors, social problems or psychosocial adjustment difficulties of the individual were reported, recorded, monitored, and care plan interventions were developed to address those observed behaviors. Evaluation of the effectiveness of those interventions was monitored on an ongoing basis by the interdisciplinary team. Non-pharmacological Interventions were implemented to help manage behaviors. Resident #143 had diagnoses including dementia with agitation, and depression. The 1/29/2025 Minimum Data Set documented the resident had severe cognitive impairment, continuous inattention, verbal and other behavioral symptoms one to three of seven days, and took antidepressant and antipsychotic medications. A 6/5/2024 physician order documented telepsychiatry appointments as needed for depression. The comprehensive care plan initiated 8/1/2024 and revised 3/20/2025, documented the resident had the potential for alteration in mood and behavior related to Alzheimer's, agitation, and anxiety. The resident was resistive to care; hit, bit, scratched, and pinched staff; and verbally threatened and swore at staff. The resident was depressed and had a history of suicidal ideation; was exit seeking and attempted to kick out windows or punch walls; was socially inappropriate and disruptive; had self-abusive acts of hitting themself in the face; refused medications and meals; and had unpredictable behaviors. Interventions included provider review of medications for intrusive and aggressive behaviors; ensure the resident held their doll or a soda bottle to prevent taking other residents' items; administer medications as ordered; approach the resident from the front in a calm, gentle manner; assure the resident did not attempt to stand on or push a chair; encourage to verbalize feelings; document behaviors; psychiatric consults as needed; monitor pain; remove from stressful situations; bring to the nurses' station if they were up early; offer drinks or snacks; offer busy work like folding clothes; and trazodone (antidepressant often used as a sleep aid) was started for increased insomnia and inappropriate wandering. (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	03/28/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/14/2024 at 4:22 PM Social Worker #37 progress note documented they discussed the resident's continued aggressive behaviors and telepsychiatry recommendations with the nurse practitioner. The resident's next telepsychiatry appointment was scheduled for 12/16/2024. The 12/16/2024 Telepsychiatry progress note by Telepsychiatry Nurse Practitioner #46 documented they saw the resident via real time audiovisual for a follow-up to the 8/28/2024 visit. There was no improvement with the resident's agitation and combativeness. The resident admitted to getting angry with staff and feeling scared at times but could not explain why. Recommendations included it may be beneficial to meet with Registered Nurse Engagement Specialist #28 to develop a non-pharmacological behavioral care plan. Staff could reschedule a follow-up appointment approximately 4 weeks after institution of recommendations to assess response. The 12/18/2024 Telepsychiatry Nurse Engagement Behavioral Care Plan Interventions by Telepsychiatry Registered Nurse #28 documented they received communication asking for additional nonpharmacological recommendations per the telepsychiatry provider's recommendation. The resident had a history of abuse from their father and ex-husband. Staff at the facility was challenged by the resident's combativeness, yelling and screaming, difficulty redirecting from exit seeking, and not sleeping through the night but on and off throughout the day. Interventions like a baby doll, one-to-one reassurance, snacks and beverages, and redirection were short-lived. The non-pharmacological interventions recommended were: - antecedent behavior consequence (before, behavior, and after charting) to assist with identifying triggers such as when the resident's behavior was best, worst, what happened before the behavior, and the environment. - when the resident was exit seeking: avoid using negatives and no statements when redirecting or distracting, approach from the front and allow the resident space without touching them while smiling and cueing them to follow. - when the resident was combative with care: provide soft music, dimmed lights while displaying positive/favorite pictures, offering a snack prior or something to occupy their hands, and always stop when the resident resisted. - provide trauma-informed care as dementia residents could live in the past; introduce self when entering the resident's room; frequent reassurance they were okay; identify triggers such as where and when the abuse took place such, were they frightened at night and stayed up because of this; or when redirecting the resident from exiting, could their combativeness be related to their history of abuse. - encourage proper sleep by maximizing bright light exposure during the day especially between 9:30 AM to 11:30 AM, shades up early in the morning and down in the evening, limit daytime napping, and provide frequent exercise opportunities. The 12/18/2024 at 12:09 Social Worker #37 progress note documented telepsychiatry recommendations were reviewed with the physician. The physician agreed and the resident's Depakote was increased from 375 milligrams to 500 milligrams at bedtime. They would follow up for effectiveness. (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	03/28/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the non-pharmacological telepsychiatry recommendations were reviewed or implemented. The 2/10/2025 Social Worker #37 Care Plan Meeting progress note did not include documentation of discussion regarding telepsychiatry non-pharmacological recommendations for the resident's behavioral symptoms. The following observations of the resident were made: - on 3/24/2025 at 12:42 PM in another resident's room, clutching their babydoll. When staff attempted redirection, the resident did not want to leave the room. The resident laid down in the other resident's bed. - on 3/27/2025 at 8:47 AM, in a room next to theirs, asleep in a stationary high back winged chair with their meal tray in front of them. At 9:02 AM, the resident was woken by staff and reminded to eat their breakfast. The resident went back to sleep after the staff member left. At 11:51 AM, asleep in a recliner chair directly in front of the nursing station. During an interview on 3/28/2025 at 9:34 AM, Certified Nurse Aide #33 stated Resident #143 wandered while grabbing other people's items and had a cart to push around. The cart was taken away because staff thought the resident might hurt someone. Resident #143 wandered a lot at night and tried to get other residents out of bed. Staff were supposed to walk with the resident. They stated staff should try to get the resident to activities, walk with them, or do distraction activities so they were not sleeping throughout the day. The resident did not have any interventions for their yelling or distress, they just tried talking to the resident. It was not a preference of the resident to have their door shut and sometimes other residents shut the door because of the resident yelling. Resident #124's yelling lessened when they were out in the common area. The resident should not be left in their room alone with the door shut when they were distressed or yelling and often tried to get out of bed when that happened. They were unaware of any television preferences for the resident. During an interview on 3/28/2025 at 9:58 AM, Licensed Practical Nurse #34 stated the Unit Manager was responsible for updating the care plans. They were unsure what interventions Resident #143 had for their behaviors. They tried walking with the resident and gave them soda as they liked that. The resident wandered a lot at night. There were no interventions to keep the resident up at night as they were taught to let the resident do what they wanted with sleep and waking. They tried aroma therapy and tried to talk to Resident #124 to calm them down. The resident should not be left in their room yelling and/or distressed without intervention. If the resident had specific television preferences, they should be utilized. (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	03/28/2025

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/2025 at 10:21 AM, Registered Nurse Unit Manager #19 stated they had meetings every Friday to discuss the effectiveness of care planned interventions. Resident #143 wandered a lot at night. The resident did not sleep much during the day, just took small naps which were appropriate for them. If the resident was sleeping a lot during the day, it was part of their care to try and get the resident to activities. Resident #124 had a lavender scent patch for comfort, and they had a little laptop they put the resident's shows on. The resident did not know why they were yelling. If a resident was in their room with the door shut yelling the staff should intervene. If the resident preferred children's cartoons for the voices, it should be care planned. It was important to have personalized behavior and wandering interventions for residents to provide comfort for the residents. Their care plan should be centered around their likes and dislikes. During an interview on 3/28/2025 at 11:59 AM, Social Worker #37 stated they were responsible for mood and behaviors, psychotropic medications, and comfort measure care plans. The care plans and the interventions should be personalized because every resident was different and required different interventions to help calm them. They reviewed notes for all residents receiving telepsychiatry and incorporated the recommendations after they were approved by the provider. They documented the review under a social services note. They stated the non-pharmacological telepsychiatry interventions from 12/2024 were not incorporated in the resident's plan of care and they should have been. They stated they were unaware of the recommendation for antecedent, behavior and consequence charting to identify triggers. It should be on the resident's care plan they had a history of abuse, and the resident did not like to be touched. They were aware Resident #124 had yelling and distressing behaviors. The resident was scared and did not understand what was happening and yelled out. The staff should not leave the resident in a room by themself when they yelled. It was important for residents with dementia to be provided with interventions when they were distressed so they were provided with comfort and did not have undo stress. 10 NYCRR 415.12 124

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	03/28/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40803 Based on observations and interviews during the recertification and abbreviated (NY00333993) surveys conducted 3/24/2025-3/28/2025, the facility did not ensure the provision of food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 lunch meals tested (3/24/2025 and 3/28/2025 lunch meals). Specifically, the 3/24/2025 lunch meal entree was difficult to cut; and the 3/28/2025 lunch meal was not served at palatable and safe temperatures. Findings include: The facility policy Food Temperature Requirements and Holding Time, revised 6/28/2019, documented the Director of Dining Services or designee was responsible for assuring the proper temperatures and holding times of foods were maintained during the preparation and service of meals. The 3/24/2025 posted lunch menu documented cube steak with brown gravy, garlic mashed potatoes, peas and onions, and pineapple chunks. The following observations and interviews were made during the 3/24/2025 lunch meal: - at 12:41 PM Resident #383 stated sometimes the food was served cold and tasted bland. - at 12:50 PM Resident #19 stated the cube steak was hard, and staff called for a replacement meal for them. - at 12:50 PM Resident # 58 stated the cube steak was tough, and staff called for a replacement meal for them. - at 12:54 PM Residents #80's spouse stated the meat was very tough. Their spouse did not have teeth, and they could not cut the cube steak with their knife. They complained for months about the meat being too tough. - at 1:18 PM Resident #10 stated their cube steak was too tough, and staff called for a meal replacement. - at 1:23 PM Resident #49's meal ticket documented the resident required food that was easy to chew. The cube steak was attempted to be cut, and force was used to move the knife back and forth. Staff called for a meal replacement. During an observation on 3/27/2025 at 11:58 AM with Licensed Practical Nurse #20, Resident #383's lunch meal was tested for taste, temperature, and palatability. The resident was provided with a replacement tray. The applesauce measured at 65.1 degrees Fahrenheit; the turkey bake was 134.6 degrees Fahrenheit; Brussels sprouts were 123.9 degrees Fahrenheit; coffee was 129.2 degrees Fahrenheit; and milk was 55.7 degrees Fahrenheit. (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	03/28/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/2025 at 12:08 PM, Licensed Practical Nurse # 20 stated they were unsure what the proper food temperatures should be, but hot food should be served hot and cold food should be served cold. During an interview on 3/28/2025 at 10:56 AM, the Food Service Director stated cold food should be served below 40 degrees Fahrenheit and hot food should be served between 140 and 150 degrees Fahrenheit. The food was tasted prior to being sent to the units and the cube steak served on 3/24/2025 was tested by Assistant Food Service Director #26 who described the cube steak as a little tough. Cube steak was a tough product, cuts of meat varied, and they were limited in the types of cube steak they could order due to budget constraints. They were aware of the significant number of meal replacements requested during the 3/24/2025 lunch meal due to reports from residents that the steak was either difficult to chew or unappealing. If a meal ticket documented easy to chew then food items should be tender enough to cut with a fork. They stated food held within a danger zone could have impacted both taste and palatability. They had not received complaints about the temperature or the quality of the food. 10NYCRR415.14(d)(1)(2) 48675