

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/06/2026
NAME OF PROVIDER OR SUPPLIER  Elderwood at Waverly		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on record review and interviews during the abbreviated survey (iQIES reference #2740895), the facility failed to ensure residents were free from physical abuse for one (1) of seven (7) residents (Resident #1) reviewed. Specifically, Resident #1 was combative during care, struck Support Aide #2, and Support Aide #2 struck the resident back in the left shoulder. The 04/30/2024 facility policy, Abuse Prevention, Identification, Investigation, Protection and Reporting documented all staff would be trained on prevention of all forms of abuse. Training would include recognizing forms of abuse. The facility would ensure supervision of staff on all shifts would occur to identify inappropriate staff behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, and directing residents that need assistance with the bathroom to urinate or defecate in their beds. Prevention included on-going assessments, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect such as physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures or throwing objects. Resident #1 had diagnoses of Alzheimer's disease. The 01/16/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, used a wheelchair and was dependent on staff for all activities of daily living. The comprehensive care plan revised 01/20/2026 documented alteration in mood/behavior due to Alzheimer's disease, communication deficits and dementia with psychotic disturbance. At times the resident was combative and resistive to care and/or refused all care. The resident could be verbally aggressive towards others. Interventions included: provide verbal cues prior to care routines; administer medications as ordered; report changes in mood/behavior to the physician; redirect/intervene and/or provide distractions during episodes of agitation; and reapproach as appropriate. The 02/10/2026 at 10:50 AM nursing progress note by the Director of Nursing documented Certified Nurse Aide #1 reported to Registered Nurse Unit Manager #7 they witnessed Support Aide #2 (referred to as Nurse Aide Trainee and clarified in interview as Support Aide #2) hit Resident #1 on the left shoulder. Certified Nurse Aide #1 and Support Aide #2 had assisted Resident #1 into their wheelchair and the resident hit Support Aide #2. Support Aide #2 stated the resident was combative during care and they held the resident's hands. When transferred, the resident hit Support Aide #2, and Support Aide #2 struck the resident in the left shoulder. Both Certified Nurse Aide #1 and Support Aide #2 left the room when the transfer into the wheelchair was completed. The 02/10/2026 at 10:55 AM nursing progress note by Registered Nurse Unit Manager #7 documented Certified Nurse Aide #1 reported Resident #1 was hit in the left shoulder. An assessment was completed; no redness, swelling or bruising was observed. Resident #1 could not say what happened due to their cognition. Registered Nurse Unit Manager #7 asked the resident if they were afraid of anyone and the resident did not respond. Resident #1 did not shy away, flinch, or act in any way afraid while Registered Nurse Unit Manager #7 was with them. The family was notified and was appreciative of the call. The 02/10/2026 facility investigation completed by the Director of Nursing documented Certified Nurse Aide #1 assisted Resident #1 with morning care and Support Aide #2 was assisting them. When Resident #1 was transferred into their wheelchair, they hit Support Aide #2 and Support Aide #2 hit the resident back on the left shoulder. Certified Nurse Aide #1 reported the (continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>incident to Registered Nurse Unit Manager #7. The Director of Nursing was notified, and upon interview, Support Aide #2 was suspended pending investigation. Resident #1 was assessed and had no injuries. They could not recall what happened. The Medical Director and family were notified. Social services would follow up with the resident. On 02/13/2026, the facility concluded abuse had occurred and Support Aide #2 was terminated. Staff statements in the 02/10/2026 Facility Investigation included: -On 02/10/2026, Support Aide #2 documented they were assisting Resident #1 with care and the resident was combative. Support Aide #2 held the resident's hands so care could be performed and after helping the resident into their chair, the resident swung at them and grabbed their badge. Support Aide #2 reacted and swatted back but did not make contact with the resident. They realized their reaction before they made contact and pulled their hand back. - On 02/10/2026, Certified Nurse Aide #1 documented they and Support Aide #2 were assisting Resident #1 into their wheelchair. Resident #1 struck Support Aide #2, and Support Aide #2 struck the resident back in their left shoulder and then Certified Nurse Aide #1 and Support Aide #2 exited the room. During an interview on 02/18/2026 at 9:45 AM, Registered Nurse Unit Manager #7 stated they were informed about the incident between Resident #1 and Support Aide #2 by Unit Clerk #31. They stated Unit Clerk #31 informed them that Support Aide #2 hit Resident #1. Registered Nurse Unit Manager #7 immediately phoned the Director of Nursing and reported the incident. During an interview on 02/18/2026 at 10:04 AM, Unit Clerk #31 stated on 02/10/2026, Certified Nurse Aide #1 told them Support Aide #2 hit Resident #1 on the shoulder. Resident #1 had been combative with care and hit Support Aide #2. They immediately reported the incident to Registered Nurse Unit Manager #7. During an interview on 02/18/26 at 10:30 AM, Certified Nurse Aide #1 stated Resident #1 could be combative with care. They observed Resident #1 hit Support Aide #2 and Support Aide #2 hit the resident's left shoulder with their right hand and stated, don't hit me. Certified Nurse Aide #1 stated the slap wasn't hard but could be heard. During an interview on 02/17/2026 at 1:42 PM, Support Aide #2 stated Resident #1 was combative with care and the resident hit them. They reacted but thought they hit the string on their badge. They denied making contact with the resident. During an interview on 02/18/2026 at 11:00 AM, the Director of Nursing stated they received a call from Registered Nurse Unit Manager #7 who stated Certified Nurse Aide #1 reported Support Aide #2 hit Resident #1 in the shoulder. Support Aide #2 was brought into the office, interviewed and re-educated immediately on abuse prevention and reporting. The Director of Nursing stated Support Aide #2 was immediately suspended following the re-education and an investigation commenced. They stated following their investigation, they concluded abuse was witnessed and the facility terminated Support Aide #2. All staff were educated on abuse prevention and reporting prior to this incident and were immediately re-educated after the incident. During an interview on 03/05/2026 at 9:42 AM, the Medical Director stated they were notified of the incident between Resident #1 and a staff member. Resident #1 was assessed by Nurse Practitioner #29, and they understood there were no injuries. They would expect to be notified of any incidents related to abuse and expected staff not to be abusive towards any resident in the facility. 10 New York Codes, Rules and Regulations 415.4</p> <p>(b)(1)(i) _____ The deficient practice was identified at past non-compliance based on the following corrective actions:-The incident was immediately reported to the Administrator, who reported it to New York State Department of Health as required. -Support Aide #2's personnel file was reviewed. There was documented evidence of education on abuse prevention and reporting prior to the incident.- Verification of social services follow up with Resident #1 to ensure there was no negative psychosocial outcome to the resident. - Verification Resident #1's care plan was reviewed and updated to reflect the 02/10/2026 incident.-Support Aide #2 was suspended on 02/10/2026, immediately following the incident and subsequently terminated. -The facility developed, implemented, and maintained an effective abuse prevention training program.-Facility-wide education was conducted on abuse prevention and reporting and was completed on 02/16/2026. -The onsite (continued on next page)</p>		

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F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	investigation included observations and interviews with staff for verification of abuse training and reporting.		