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	03/11/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record reviews and interviews during the facility failed to protect residents from sexual abuse for six (6) of six (6) residents (Residents #3, #4, #5, #6, #7, and #8). Specifically, Resident #2 was found in separate sexually inappropriate situations with six (6) residents, all of whom had impaired cognitive function with the exception of Resident #5. The facility's failure to protect residents from sexual abuse placed all 176 residents in the facility at risk of abuse. This resulted in actual harm for Residents #3, #4, #5, #6, #7, and #8 that was Immediate Jeopardy and Substantial Quality of Care for residents' health and safety. Findings include: The facility policy, Abuse Prevention, Identification, Investigation, Protection and Reporting, dated 04/30/2024, documented all staff would be trained on prevention of all forms of abuse. Training would include recognizing forms of abuse. Prevention included on-going assessments, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect including wandering into other's rooms and sexually aggressive behavior such as saying sexually inappropriate things and sexually inappropriate touching and/or grabbing.Resident #2 had diagnoses including Alzheimer's disease. The 07/10/2025 Minimum Data Set (a resident assessment tool) documented the resident had moderate cognitive impairment, used a walker, walked independently, and had no behavioral symptoms. Resident #3 had diagnoses including Alzheimer's disease. The 07/03/2025 Minimum Data Set documented the resident had severe cognitive impairment, walked independently, had no behaviors, and did not wander. Resident #4 had diagnoses including Alzheimer's disease. The 08/13/2025 Minimum Data Set documented the resident had severely impaired cognition, had no behaviors, did not wander, used a wheelchair, and was dependent on staff for all mobility. Resident #5 had diagnoses including epilepsy (seizure disorder) and dementia. The 10/01/2025 Minimum Data Set documented the resident had intact cognition, had no behaviors, did not wander, used a wheelchair, and was dependent on staff for all mobility. Resident #6 had diagnoses including Alzheimer's disease. The 12/10/2025 Minimum Data Set documented the resident had severely impaired cognition, had no behaviors, did not wander, used a wheelchair, and was dependent on staff for all mobility. Resident #7 had diagnoses including Alzheimer's disease. The 11/26/2025 Minimum Data Set documented the resident had severely impaired cognition, had inattention and disorganized thinking, had no behaviors, did not wander, used a wheelchair, and was dependent on staff for all mobility. Resident #8 had diagnoses including Alzheimer's disease. The 05/29/2025 Minimum Data Set documented the resident had severely impaired cognition, had no behaviors, did not wander, used a wheelchair, and was dependent on staff for all mobility. Incident #1:Resident #2's comprehensive care plan initiated 04/03/2025, documented the resident was at risk for alterations in mood/behavior related to Alzheimer's disease without behavioral disturbance. Interventions included: document mood/behavior status changes and report to the physician; redirect, intervene, or provide distraction for periods of agitation; approach from the front in a calm, gentle manner.Resident #8's comprehensive care plan revised 06/05/2025, documented the resident had trauma with anxiety related to traumatic war experience/traumatic event (sexual, accident, death), environment change, preoccupation with the experience as evidenced by fear, transfer trauma, withdrawal from support system. Interventions (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	included identifying and eliminating triggers in the environment and developing a trusting relationship. The 08/11/2025 at 1:30 PM Accident and Incident Report completed by Registered Nurse #5, documented a resident (identified as Resident #2) was found in Resident #8's bed with their hand in a rubbing motion, down Resident #8's brief. Resident #2 was immediately removed from the room and moved to another unit. A stop sign remained in place on Resident #8's doorway. The Accident and Incident report did not include staff statements or documentation related to Resident #2's activities prior to being found in Resident #8's bed, or when the residents were last observed.There was no documented evidence of social work follow up or updated interventions for Resident #8 related to the 08/11/2025 incident or the resident's potential to be a victim of sexual abuse. There was no documented evidence of the intervention of the stop sign across the resident's door. Resident #2's care plan was revised on 08/11/2025 to include the resident was moved to another unit with alert residents, medications were reviewed and adjusted, and behavioral monitoring was initiated. The facility Census List documented Resident #2 was moved from the fourth floor to the second floor on 08/11/2025 and was moved back to the fourth floor on 08/19/2025. There was no documented evidence Resident #2's care plan was updated to reflect the move back to the fourth floor, or any interventions related to their sexually inappropriate behaviors. Incident #2: Resident #3's comprehensive care plan, initiated 04/02/2025, documented the resident was at risk or had been the recipient of verbal or physical altercations from/with other residents and was at risk for elopement and unsafe wandering. Interventions included: assess for inappropriate behavior and unmet needs; engage in diversional activities; monitor for negative effects from an altercation; and monitor whereabouts due to unsafe wandering. The 09/17/2025 at 10:16 PM Registered Nurse Unit Manager #12 progress note documented Resident #3 was found in Resident #2's bed. Resident #3 was wearing a pajama top, and no bottoms and Resident #2 had no clothes on. They were noted to be lying in a spooning position, sleeping. Resident #3 was assessed for injuries, no redness noted (location not documented), and the resident denied pain. The residents were immediately separated.The 09/17/2025 Accident/Incident Report documented Resident #3 was found in Resident #2's bed, wearing a pajama top and no bottoms, Resident #2 was not wearing any clothing. They were lying in a spooning position, with Resident #2 behind Resident #3, asleep. The residents were separated. The 09/17/2025 Witness Accounts of Accident/Incident, completed by Certified Nurse Aide #4 and Support Aide #3 documented they found Residents #2 and #3 sleeping in Resident #2's bed. Resident #2 had no clothing on, and Resident #3 was in a shirt. There appeared to be fluid on the sheet.The 09/22/2025 Witness Account of Accident/Incident completed by Licensed Practical Nurse #32 documented they were made aware a resident (Resident #3) was found undressed in another resident's (Resident #2) room and the residents were in bed together. Licensed Practical Nurse #32 was in the room earlier for a dressing change for Resident #2's roommate, the curtains were pulled (between the bed), and the nurse did not hear anything from Resident #2's side of the room. There was no documented evidence of a care plan update or implemented interventions for Resident #3 related to this incident or their potential to be a victim of sexual abuse. Resident #2's behavior care plan was updated to include a resident was found in their bed on 09/17/2025 and no inappropriate touching was witnessed at the time of the incident. There were no new or revised interventions related to this incident. During an interview on 02/18/2026 at 2:06 PM, Support Aide #3 stated on 09/17/2025, they discovered Resident #3 lying in Resident #2's bed. Resident #2 was completely naked, and Resident #3 was naked from the waist down. Resident #3 was known to wander but not to climb in anyone's bed. Resident #3 was immediately removed from the room and covered. Support Aide #3 stated they were unaware of any safety measures implemented following the incident, and Resident #2 was later transferred to another unit. During an interview on 02/18/2026 at 2:48 PM, Registered Nurse Unit Manager #12 stated Resident #2 liked the female residents and they witnessed Resident #2 kissing and hugging female residents on three (3) to four (4) prior occasions. Resident #2 was redirected and told the behavior was inappropriate. On 09/17/2025, they were told Resident #3 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	was discovered in Resident #2's bed. The residents were separated, and Resident #2 was transferred to a different unit. Incident #3:Resident #4's comprehensive care plan, initiated 09/19/2025 documented they were at risk or had been the recipient of verbal or physical altercations from/with other residents. Interventions included: diversional activities; intervene immediately if altercations were observed; monitor for negative effects of altercation; move away from other residents who were at high risk to become physically or verbally aggressive. The undated Facility Investigation signed by the Director of Nursing and the Administrator, documented on 09/20/2025 at 8:00 AM, Resident #2 was observed in the dining room, removing their hand from Resident #4's thigh area. Resident #2's hand was on top of Resident #4's pants and the residents were kissing. Resident #2 stated they thought they were kissing their spouse. Resident #2 was recently moved from the fourth floor to the first floor on 09/19/2025 due to a similar incident. The 09/20/2025 Witness Account of Accident/Incident form completed by Certified Nurse Aide #6 documented they entered the dining room, Residents #2 and #3 were kissing, and Resident #2 was removing their hand from Resident #4's thigh area. The 09/20/2025 at 2:23 PM Registered Nurse #26 progress note documented Resident #2 was observed kissing Resident #4 with their hands between Resident #4's legs. Resident #2 was immediately removed from the area. Resident #4 was assessed for injuries and did not recall being kissed or any other inappropriate behavior. No injuries or complaints of discomfort were noted. There was no documented evidence Resident #4's care plan was revised to address the incident on 09/20/2025. Resident #2's behavior care plan interventions were revised on 09/20/2025 to include: medication changes to lower libido; eat in the dining room near the nurses' station; 15-minute paper checks for one (1) day; behavioral monitoring; and 1:1 activities for diversion.During an interview on 02/17/2026 at 11:39 AM Resident #4 stated they were touched a while ago by a gentleman that lived there, they could not recall who it was, and it hasn't happened in a while, thank God. The resident stated the nurses did not do anything about it and they did not recall the details. Incident #4:Resident #5's comprehensive care plan initiated 09/19/2025 documented they were at risk or had been the recipient of verbal or physical altercations from/with other residents. Interventions included: diversional activities; intervene immediately if altercation was observed; monitor for negative effects of altercation; and move away from other residents who were at high risk to become physically or verbally aggressive. The 11/21/2025 at 4:55 PM Incident Report completed by the Director of Nursing documented a certified nurse aide walked by the activity/dining room and observed Resident #2 trying to kiss Resident #5 on the lips and rubbing their breast. Resident #5 was observed turning their head away from Resident #2 and when interviewed, stated it was not OK for Resident #2 to be touching their breast. The residents were immediately separated, and the Registered Nurse Supervisor (unidentified) and Director of Nursing were notified. The interventions implemented included to keep Resident #2 away from Resident #5 and when in the activity room, place them on opposite sides of the table. There were no documented witness statements included with the investigation.Nursing progress notes for Resident #5 on 11/22/2025 at 6:27 AM, 1:39 PM, and 8:46 PM, entered by the Director of Nursing, documented no late injuries were noted from the 11/21/2025 incident. There was no documented evidence of nursing or social services follow up with Resident #5 related to their emotional/psychological status following the 11/21/2025 incident. On 11/21/2025, Resident #2's behavior care plan revision documented when the resident was in the activity room, encourage them to not to sit too close to female residents.There was no documented evidence of care plan revision(s) for Resident #5 following the incident. During an interview on 02/28/2026 at 9:30 AM Resident #5 stated they did not like what happened to them regarding the 11/21/2025 incident with Resident #2. Resident #5 stated they did not recall details about the incident.Incident #5:Resident #6's comprehensive care plan revised 12/23/2025 documented the resident had the potential for alteration in mood/behavior related to Alzheimer's disease. Interventions included: document mood/behavior changes; redirect during episodes of agitation; and seat the resident out of direct contact with other residents walking by. The undated Facility Investigation documented on 02/12/2026 at 6:10 PM, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Certified Nurse Aides #6 and #34 entered Resident #6's room and witnessed Resident #2 sitting by Resident #6's bed leaning on the bed. Resident #2 had both their hands under the sheet and did not respond when Certified Nurse Aide #34 told them to stop and to leave the room. The aide repeated their instructions and assisted Resident #2 away from Resident #6 and out of the room. Resident #6's incontinence brief was almost completely unsecured, and the resident stated, it hurts. No open areas to the skin were noted upon assessment, and Resident #6 did not voice any further complaints following the incident. Resident #2 was moved to a room closer to the nurses' station and a stop sign was placed in Resident #6's doorway. Resident #2's behavior care plan was revised on 02/12/2026 and documented the resident's room was moved closer to the nursing station for closer monitoring and to keep them away from Resident #6.Resident #6's care plan was updated on 02/13/2026 to include the resident was at risk or has been the recipient of inappropriate touching by another resident. Interventions included: a stop sign was added to their door; diversional activities; and to keep them away from Resident #2.Incident #6:Resident #7's comprehensive care plan revised 06/18/2025 documented they were at risk or had been the recipient of verbal or physical altercations from/with other residents. Interventions included: intervene immediately if altercations were observed; monitor for negative effects of altercation; and move away from other residents who were at high risk to become physically or verbally aggressive.The 02/17/2026 at 4:31 AM Licensed Practical Nurse #11 progress noted documented Resident #2 was found lying in Resident #7's bed. Resident #7 was yelling help, which they did most of the shift. No contact was noted between the residents. Resident #2 was very combative when trying to get them back to their own bed. The 02/18/2026 at 2:43 AM Licensed Practical Nurse #11 progress note documented Resident #2 was found in Resident #7's room at 10:30 PM, sitting on the bed and holding Resident #7's hand. Resident #7 had no comment. Resident #2 was removed from the room. Resident #2 had been up wandering the unit several times during the night. There were no documented care plan revisions for Resident #7 following the incident. During an interview on 02/18/2026 at 4:00 PM, Licensed Practical Nurse #11 stated Resident #2 wandered and was found in Resident #7's room sitting on their bed. They became agitated when staff attempted to redirect them. Licensed Practical Nurse #11 stated there were no safety measures in place to protect female residents, aside from monitoring Resident #2. They stated it was hard to control Resident #2's wandering at night. During an interview on 02/19/2026 at 8:35 AM, Certified Nurse Aide #13 stated they heard of Resident #2's prior sexual inappropriate touching with one (1) or two (2) female residents but never witnessed any incidents. They stated they used the Kardex (care instructions) or report from the Unit Manager for instructions on resident care. Staff were verbally told to monitor Resident #2 for inappropriate behavior. They were unsure if monitoring was listed on the resident's care instructions. During an interview on 02/19/2026 at 10:23 AM, Social Worker #14 stated they knew of the 02/13/2026 incident involving Resident #2's sexually inappropriate behaviors with Resident #6. They had prior knowledge of incidents involving Resident #2 on the fourth floor. They stated if residents were only holding hands, it was innocent. Staff were told to redirect Resident #2 if they witnessed anything inappropriate. There were no safety measures in place to protect Residents #3, #4, #5, #6 or #7. No follow ups or psychological evaluations were performed, they would just look at the residents and watch their body language. Social Worker #14 stated they did not normally work with Resident #2 and was covering for another social worker. The Director of Social Work was new in their role. They were unaware of how many incidents Resident #2 was involved in. During an interview on 02/19/2026 at 10:46 AM the Director of Social Work stated they were informed by the Administrator Resident #2 had a room change from the fourth floor to the first floor. They were told it was due to sexually inappropriate behaviors with female residents, but they did not have all the details. They thought there was another social worker working on the fourth floor at that time. The Director of Social Work stated they also had knowledge of Resident #2's sexually inappropriate behaviors in September 2025 since moving down to the first floor. They did not have many progress notes related to Resident #2. They stated they did not complete any follow up (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assessments on the female residents involved and no psychological evaluations were ordered. They thought the residents were followed by the medical providers. Stop signs were placed on the female resident's doors and a psychological evaluation referral was in place for Resident #2. They did not know of any other specific interventions to protect the female residents. They stated it was all staffs' responsibility to make sure the residents' care plans were effective. During an interview on 02/19/2026 at 12:45 PM, the Director of Nursing stated they were aware of Resident #2's sexually inappropriate behaviors since September 2025. They were informed by Registered Nurse Unit Manager #12 that Resident #3 was found in Resident #2's bed (on 09/17/2025) and they had no clothes on. They stated they assessed Resident #3. The interventions to protect residents included a unit and room change for Resident #2. They were aware of the subsequent incidents involving Resident #2 with Residents #4, #5, #6 and #7. Interventions following these incidents were stop signs placed on the doors of the female residents and medication changes for Resident #2. There was no follow-up by social services with the female residents. The facility did not employ psychologists, and social services staff were responsible for following up with victim residents. During an interview on 03/05/2026 at 9:42 AM, the Medical Director stated they were recently made aware of Resident #2's inappropriate sexual behaviors. They were notified in February 2026 interventions were not effective. They stated non-pharmacological interventions included moving the resident closer to the nurses' station and utilizing stop signs in doorways. They stated they did not like to medicate residents without knowing the context; often medication would mask the real issue. Medical intervention could not fix the resident. They stated they worked with staff to utilize the best interventions. The Medical Director stated they expected to be notified of any inappropriate sexual behaviors with residents. _____Immediate Jeopardy was identified and the Director of Nursing was notified on 02/19/2026 at 3:40 PM. Immediate Jeopardy was removed on 02/20/2026 at 2:59 PM prior to survey exit based on the following corrective actions:-Resident #2's care plan was revised to show 1:1 supervision at all times. All residents who resided on the first floor South Unit had their care plans revised to be at risk for a victim of abuse.-On 2/20/2026 at 10:15 AM and 2:01 PM, Resident #2 was observed with 1:1 supervision with no concerns.-All nursing staff working on South Unit were educated on Resident #2's revised care plan. The information was confirmed by signature records. -On 02/20/2026, the Medical Director and Nurse Practitioner #29 assessed Resident #2's medications and made changes. -A referral for a psychiatric evaluation of Resident #2 was made with an appointment date of 02/24/2026. -All staff were re-educated on recognizing and reporting abuse. On 02/20/2026 at 12:30 PM, 91% of staff at the facility were educated. Any staff not available for education due to vacation, illness, etc. will be re-educated prior to their next scheduled shift. -On 02/20/2026, education was verified through staff interviews including licensed practical nurses, certified nurse aides, support aides, activities staff, housekeeping staff, and clerical staff. Education signature sheets were reviewed and verified with a full staffing list. -All residents on the South Unit were interviewed by members of the Interdisciplinary Team on 02/19/2026 and 02/20/2026 to rule out any further instances of unreported abuse. Progress notes from the last 30 days were also reviewed for those residents. No concerns were identified. Documentation was provided by the Administrator detailing the interviews and progress note reviews as noted. - The surveyor reviewed Nursing Progress Notes for Residents #3, #4, #5, #6, #7, and #8 and no additional concerns were identified. -On 2/20/2026, Social Worker #14 followed up with Residents #3, #4, #5, #6, #7, and #8 to ensure no psychosocial/emotional harm was noted. Documentation was provided detailing the social workers' follow-up. 10 New York Codes, Rules and Regulations 415.4(b)(1)(i)