STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335391	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Grand Island	2850 Grand Island Blvd Grand Island, NY 14072

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review conducted during an Abbreviated survey (Complaint #2674904), the facility did not ensure that all alleged abuse violations were reported immediately but not later than two (2) hours after the allegation was made to the Administrator of the facility and to the State Survey Agency for one (1) (Resident #1) of three (3) residents reviewed. Specifically, staff did not report an allegation of physical abuse to the Administrator immediately which resulted in delayed reporting to the New York State Department of Health within the required time frames.The finding is: The policy titled Abuse Prevention, Identification, Protection and Reporting of Victims last revised on 4/30/2024 documented all facility staff were required to immediately report to the Administrator, Director of Nursing or designee when there was an observed act or suspicion of abuse, mistreatment or neglect. The facility Administrator or designee will report all alleged violations to, state agencies immediately, but no later than two (2) hours after the alleged abuse, mistreatment, and as required agencies (law enforcement, adult protective services, licensing authorities, state nurse aide registries when applicable) with in specified timeframes. All staff will be trained in identifying abuse. Resident #1 had diagnoses which included Alzheimer's Disease, anxiety and depression. The Minimum Data Set (a resident assessment tool) dated 11/13/2025 documented Resident #1 was severely cognitively impaired, was sometimes understood and sometimes understands, and had verbal and physical behavioral symptoms directed towards others. The comprehensive care plan revised on 02/11/2025, documented that Resident #1 had severe cognitive impairment, required assistance with activities of daily living, and ambulated independently. The resident had a history of confrontations with others. The plan included to approach the resident from the front in a calm gentle manner, explain all aspects of care, and if they became agitated, staff were to stop, ensure safety, then reapproach. Review of the New York State Department of Health Complaint Tracking System Complaint/Incident Investigation Report revealed the date/time of the alleged incident was on 11/18/2025 at 8:06AM. The date/time the Administrator was first made aware of the incident was 11/20/2025 at 5:57AM. It was submitted by the facility to the New York State Department of Health on 11/20/2025 at 8:13AM. The facility investigation dated 11/20/2025 at 8:13AM documented an altercation between a staff member and Resident #1 occurred on Tuesday 11/18/2025 at 5:57AM. Certified Nursing Assistant #2 left a note for the Director of Nursing that stated Resident #1 spat in Certified Nursing Assistant #1's face, then Certified Nursing Assistant #1 grabbed Resident #1's hair and slammed Resident #1's face on the bed. There were no additional witnesses to the alleged abuse. During a telephone interview on 12/02/2025 at 10:26AM, Certified Nursing Assistant #2 stated Resident #1 was combative when they provided care. They requested help from Certified Nursing Assistant #1 on 11/19/2025 at 5:57AM. Together they stood Resident #1 up at the side of the bed and provided fecal incontinent care. Certified Nursing Assistant #1 held Resident #1's hands while Certified Nursing Assistant #2 provided the care. Resident #1 spat in Certified Nursing Assistant #1's face, then Certified Nursing Assistant #1 grabbed Resident #1's hair and slammed their face into the mattress. Certified Nursing Assistant #2 was shocked and did not say anything to Certified Nursing Assistant #1. They knew they should have reported the abuse immediately, but they were afraid that Certified Nursing Assistant #1 would retaliate. Certified Nursing Assistant #2 then reported the abuse on 11/20/2025 to Registered Nurse #1 Nurse Supervisor and left a note under the Director of Nursing's door. During a telephone interview on 12/02/2025 at 10:59AM, Certified Nursing Assistant #1 denied grabbing Resident #1 and slamming Resident #1's face into the bed. That would be abuse, and they would never abuse a resident. During a telephone interview on 12/02/2025 at 11:43AM, Registered Nurse #1 Nursing Supervisor stated the alleged abuse was reported by Certified Nursing Assistant #2 on 11/20/2025. They questioned why they waited twenty-four (24) hours to report the abuse. They should have reported the incident immediately on 11/19/2025. During an interview on 12/02/2025 at 12:44PM, Registered Nurse #2 Unit Manager would have expected Certified Nursing Assistant #2 to intervene and immediately inform the nurse on duty. The nurse would then notify the nursing supervisor who then would notify the Director of Nursing or the Administrator. Allegations of abuse were required to be reported the Health Department within (2) two-hours. During an observation on 12/02/2025 at 1:20 PM, Resident #1 was independently ambulating in the halls on the unit with supervision. Resident #1 could not recall the incident, was pleasant and calm. No behaviors were noted, and no signs of physical abuse were identified. Staff were observed treating Resident #1 with respect and dignity. During an interview on 12/02/2025 at 2:00PM, the Director of Nursing stated the dates on the Complaint/Incident