STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335500	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Lockport	104 Old Niagara Road Lockport, NY 14094

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 - 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** Based on interviews and record reviews conducted during survey, the facility failed to ensure that the residents' environment remained as free of accidents as possible, and that each resident receives adequate supervision and assistance devices to prevent accidents for one (1) (Resident #1) of three (3) residents reviewed for accidents. Specifically, on 12/24/2025, the facility failed to use two (2)-person bed mobility assistance, from lying to sitting on the edge of the bed, resulting in Resident #1 falling to the floor, sustaining a left hip fracture requiring an open reduction internal fixation (ORIF-surgical procedure to realign and secure broken bones with metal fasteners). This resulted in actual harm to Resident #1 that is not Immediate Jeopardy. The findings are: The policy titled Comprehensive Care Plan, dated 06/18/2025, documented the nursing home will develop and implement a comprehensive, person-centered care plan for each resident that addresses the resident's medical, nursing, mental, and psychosocial needs and will be reviewed and revised regularly to ensure optimal care. Components of the care plan included the services to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. The policy titled Kardex (care guide), dated 10/11/2021, documented a Kardex will be developed and available for all residents to act as a quick reference to particular needs of each individual. The Kardex will be referenced prior to rendering care to ensure that care is provided appropriately. The Certified Nursing Assistant (CNA) Job Description, dated 07/2022, documented Certified Nursing Assistants assist with ensuring the health and well-being of the residents by providing direct nursing and personal care support. The Certified Nursing Assistant is responsible for assisting residents with all aspects of daily living activities (basic self-care tasks necessary for everyday functioning which include personal hygiene, dressing, eating, toileting, and mobility/transferring) ensuring that the highest degree of quality resident care is maintained at all times. Essential job functions included assisting residents with the following Activities of Daily Living (ADLs), according to their plan of care, individual needs and care preferences: bathing, grooming, dressing, toileting, eating, exercising, positioning, transferring, ambulation, and transportation. Resident #1 had diagnoses including cerebral infarction (stroke) with left hemiplegia (paralysis)/hemiplegia (weakness), aphasia (absence or difficulty with speech), and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 10/16/2025, documented the resident had moderate cognitive impairment and was dependent (helper does ALL of the effort, resident does none of the effort to complete the activity or the assistance of two (2) or more helpers are required for the resident to complete the activity) for lying to sitting on side of bed.The Comprehensive Care Plan initiated on 12/08/2023 documented Resident #1 had a deficit in activity of daily living function related to cerebral vascular accident (stroke). Interventions included bed mobility (lying to sitting on side of bed) substantial or maximal assistance/two (2) plus person physical assist. The Progress Note completed by Registered Nurse #1 dated 12/24/2025 at 9:08 AM documented Resident #1 had fallen out of bed. Resident reported pain in both hips and was noted to be drawing left leg up to chest due to pain. Three (3) staff members assisted the resident back to bed via mechanical lift (device used to raise or lower people). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	Medical Doctor was notified and an order received to send the resident to the hospital for evaluation. The Progress Note completed by Registered Nurse #1 dated 12/24/2025 at 11:09 AM documented the hospital emergency department updated the facility with x-ray results of left intertrochanteric (hip) fracture. The facility Complaint/Incident Investigation Report 2700648 (5-day report sent by the facility), received 12/27/2025, documented Certified Nursing Assistant #1 provided care to Resident #1 prior to the fall, sat the resident on the side of the bed, left the room to get assistance and a mechanical lift to transfer Resident #1 out of bed. Care plan review revealed Resident #1 required assistance from two (2) staff members for sitting on side of bed. The care plan was violated when Certified Nursing Assistant #1 did not get a second person to assist Resident #1 from lying to sitting on side of bed. Certified Nursing Assistant #1 was given a final disciplinary action for improper conduct and violation of work expectations. Further education was provided on importance of reading and following resident care plans prior to providing care. The hospital Discharge summary dated [DATE] documented Resident #1 sustained a left hip fracture and underwent an open reduction internal fixation of the fracture on 12/26/2025. During a telephone interview on 03/12/26 at 9:36 AM, Certified Nursing Assistant #1 stated on 12/23/2025, they assisted Resident #1 to a sitting position on the side of the bed, without assistance from any other staff members, left Resident #1 sitting on the edge of the bed while they left the room to get a mechanical lift and a staff member to assist with the transfer of Resident #1 from the bed to a chair. When they returned to the room, Resident #1 was on the floor. Certified Nursing Assistant #1 stated they immediately notified the nurse. Certified Nursing Assistant #1 stated they did not review Resident #1's Kardex prior to providing care for Resident #1 because they had taken care of Resident #1 a few weeks prior. During an interview on 03/12/2026 at 10:53 AM, Registered Nurse #1 stated Certified Nursing Assistant #1 reported to them on 12/24/2025 that Resident #1 had fallen. Resident #1 was on the floor next to the bed, the Registered Nurse performed an assessment of the resident and was concerned regarding Resident #1's level of pain and complaints of headache. Certified Nursing Assistant #1 had told Registered Nurse #1 they had left the resident on the side of the bed and left the room to get a mechanical lift. Additionally, Resident #1 required maximal assistance of two (2) staff members to move from lying to sitting on side of bed secondary to poor trunk control unable to support self in an upright position unassisted. During an interview on 03/12/2026 at 11:00 AM, the Director of Nursing stated Certified Nursing Assistant #1 violated the care plan by not providing maximal assistance of two (2) staff members and leaving Resident #1 sitting on the side of the bed unassisted. Additionally, they stated staff are expected to review the resident Kardex prior to providing resident care. During a telephone interview on 03/12/2026 at 2:12 PM, the Nurse Practitioner stated Resident #1 had a history of cerebral vascular accident and required two (2)-person assistance with sitting on the edge of the bed because they were unable to sit alone unsupported. Additionally, they expected facility staff to follow resident care plans when providing care to prevent accidents. During a telephone interview on 03/13/2026 at 8:31 AM, the Medical Director stated they expected facility staff to follow resident care plans and Resident #1 sustained an injury when staff did not follow the care plan. During a telephone interview on 03/13/2026 at 10:36 AM, the Administrator stated all staff are expected to follow the resident care plan when providing care. 10 New York Code Rules Regulations (NYCRR) 415.12(h)(2)