STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335577	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Lancaster	1818 Como Park Blvd Lancaster, NY 14086

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the Abbreviated Survey (2615979), the facility did not ensure the resident's right to be free from verbal abuse for one (1) (Resident #1) of three (3) residents reviewed. Specifically, based on audio recording and facility surveillance footage, a maintenance staff member was verbally abusive to Resident #1. The finding is:The policy titled Abuse Prevention, Identification, Investigation, Protection and Reporting dated 4/30/24 documented the facility will provide protection for the health, welfare and rights of each resident residing in the facility. The facility Administrator and the interdisciplinary team will identify, correct, and intervene in situations in which abuse, mistreatment, neglect, exploitation, and or misappropriation of resident property is more likely to occur by ensuring supervision of staff on all shifts occur to identify inappropriate staff behaviors, such as using derogatory language.The undated New York State Department of Health document titled Your Rights as a Nursing Home Resident in New York State documented as a resident in this facility you have the right to be free from physical, sexual, mental, and verbal abuse, corporal punishment, financial exploitation, and involuntary seclusion including physical and chemical restraints. Resident #1 had diagnoses including fracture of the left leg, muscle weakness, and obesity. The Minimum Data Set (a resident assessment tool) dated 09/12/2025 documented Resident #1 had intact cognition, was understood and understands. The comprehensive care plan dated 09/11/2025 documented Resident #1 was an independent decision maker. The Internet Quality Improvement & Evaluation System Complaint/Incident Investigation Report received by the New York State Department of Health on 09/20/2025 documented an alleged incident occurred on 09/11/2025 at 08:30AM between Maintenance Assistant # 1 and Resident #1. Resident #1 alleged that a staff member entered their room to check something in the bathroom and then yelled at Resident #1 about not spitting on an employee. Resident #1 then called 911.Review of the facility investigation dated 09/11/2025 documented Registered Nurse #6, Unit Manager went into Resident #1's room on 09/11/2025 at 8:20AM and addressed concerns from the night before. Registered Nurse #6 Unit Manager reported at the morning meeting at 9:00AM, that at 8:20AM Resident #1 made a gesture of spitting at them, was rude and swore. Maintenance Assistant # 1 entered Resident #1's room at 8:31AM to check something in the bathroom and started yelling repeatedly at Resident #1 not to spit in Registered Nurse #6 Unit Manager's face. Resident #1 called 911. On 09/11/2025 at 9:59AM a police officer arrived at the facility. Resident #1 alleged that they were threatened and assaulted by Maintenance Assistant #1. Resident #1 alleged that Maintenance Assistant # 1 came into their room and repeated multiple times not to spit on Registered Nurse #6 Unit Manager. In addition, there was audio surveillance recorded by Resident #1, facility video footage, and there were no other witnesses. Maintenance Assistant # 1 admitted that they confronted Resident #1 and told them not to spit at Registered Nurse #6, Unit Manager.Review of Resident #1's written statement dated 09/11/2025 documented they had a few care concerns from the previous evening on 09/10/2025. Registered Nurse #6 Unit Manager had entered their room in the morning on 09/11/2025 and stated to Resident #1 You have been giving problems since last night. Resident #1 stated that they wanted to be discharged , and they felt uncomfortable at the facility. Registered Nurse #6 Unit Manager stated to Resident #1 that they were not discharging them, and told Resident #1 they could go against medical advice and to find their own way to the front, and that they would receive no care if they left. Resident #1 then asked Registered Nurse #6 Unit Manager to leave their room. Ten minutes later Maintenance Assistant # 1 busted into Resident #1's room yelling, making false claims, got in their face and stated, we are going to get you up out of here. Resident #1 immediately dialed 911 then emailed the Administrator.Review of Registered Nurse #6 Unit Manager's verbal and typed statement documented by the Administrator on 09/11/2025 that Registered Nurse #4 had a difficult time with Resident #1, and they went to speak with Resident #1 and address their concerns. Registered Nurse #6 Unit Manager and Registered Nurse #4 went down to Resident #1's room. Registered Nurse #4 stood at the doorway while Registered Nurse #6 Unit Manager addressed Resident #1 in their wheelchair in front of the bathroom door. Resident #1 immediately said they were going to be discharged . Registered Nurse #6 Unit Manager stated to Resident #1 they were not going to be discharged because they were being non-complaint with care. Resident #1 said the (expletive) you are and Registered Nurse #6 Unit Manager informed Resident #1 of their right to leave against medical advice. As Registered Nurse #6 Unit Manager left the room Resident #1 puckered their lips as if they were going to spit on them. Registered Nurse #6 Unit Manager repeated to

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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. Based on interview, and record review conducted during an Abbreviated survey (2615979) the facility did not ensure that all alleged violations involving abuse are reported immediately but not later than 2-hours after the allegation is made if the events that cause the allegation involve abuse, to the Administrator of the facility and to other officials (including to the State Survey Agency) for one (1) (Residents #1) of three (3) residents reviewed for abuse. Specifically, an allegation of staff to resident verbal and physical abuse was not reported to the New York State Department of Health within the required (2) two-hour timeframe. The finding is: Refer to F 600 Freedom from Abuse and Neglect, scope and severity D The policy titled Abuse Prevention, Identification, Investigation, Protection and Reporting dated 04/30/2024 documented the facility Administrator or designee will report all alleged violations of abuse to state agencies immediately, but no later than (2) two hours after the allegation of abuse, mistreatment; and as required to all other required agencies (e.g., law enforcement, adult protective services, licensing authorities, stated nurse aide registries, etc., when applicable) within specified timeframes. Review of the Minimum Data Set (a resident assessment tool) dated 09/12/2025 documented Resident #1 had intact cognition, was understood and understands. The Internet Quality Improvement and Evaluation System (IQIES) Complaint/Incident Investigation Report received by the New York State Department of Health on 09/20/2025 documented an alleged incident occurred on 09/11/2025 at 8:30 AM. The Administrator was first made aware of the incident on 09/11/2025 at 10:11 AM. The facility did not report the alleged abuse to the State Agency until 09/15/2025 at 3:18 PM. Review of the facility investigation dated 09/11/2025 revealed a potential altercation between a staff member and the resident occurred on 09/11/2025 at 8:30 AM. Registered Nurse #6, Unit Manager went into Resident #1's room at 8:20 AM and addressed concerns from the night before. During that time, Registered Nurse #6 stated that Resident #1 made a gesture of spitting at them, was rude and swore. Maintenance Assistant #1 entered Resident #1's room at 8:31 AM and told Resident #1 not to spit in Registered Nurse Unit Manager #6's face. Resident #1 called 911 (emergency services). On 09/11/2025 at 9:59 AM a police officer arrived at the facility. Resident #1 alleged that they were threatened and assaulted by Maintenance Assistant #1. Resident #1 alleged that Maintenance Assistant #1 came into their room and repeated multiple times not to spit on Registered Nurse #6 Unit Manager. Resident #1 also alleged that Maintenance Assistant #1 got in their personal space and made contact with their #1's broken ankle and stated Maintenance Assistant #1 was going to beat their (expletive). The facility investigation concluded verbal abuse had occurred. During an interview on 11/07/2025 at 1:35 PM, the Administrator stated they were made aware of the allegation on 09/11/2025 at 9:07 AM when an email complaint was received from Resident #1. The Administrator stated they did not report the alleged verbal and physical abuse to the State Agency until 09/12/2025 at 12:54 PM and should have reported it within (2) two hours as required but somehow forgot. 10NYCRR 415.4(b) (4)