STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335678	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Liverpool	4800 Bear Road Liverpool, NY 13088

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interviews and record review during the recertification survey, the facility did not ensure that views, grievances, or recommendations voiced by residents during Resident Council group meetings were considered, acted upon, and responded to with a rationale for nine (9) of nine (9) anonymous residents present at the resident group meeting and one additional resident interviewed (Resident #17). Specifically, nine (9) anonymous residents at the resident group meeting and one additional resident interviewed (Resident #17) stated they did not receive responses to topics or concerns addressed in prior Resident Council meetings. Additionally, there was no documented evidence that the residents' voiced concerns were investigated, and rationales or responses were provided to the residents.Findings include: The facility policy Resident Council Policy, revised 12/15/2025, documented the Director of Activities was the appointed staff member to act as a liaison between the council and the administration staff for reporting problems, issues, and suggestions discussed by the residents at the council meetings. The Administrator or appropriate department head was to address problems, complaints, or issues reported at resident council meetings and submit a written response upon request.During a resident group meeting on 02/02/2026 at 11:04 AM, nine (9) anonymous residents stated the facility did not always follow up, address, or resolve their concerns. They stated missing clothing was a big issue and missing items were not replaced or returned if the resident did not have a receipt of purchase. There were also concerns with inadequate nursing and kitchen staffing not addressed with the group.During an interview on 02/05/2026 at 9:54 AM, Resident #17 stated they were missing several items of clothing. They previously brought the concern up in resident council, but nothing was done.Resident Council meeting minutes documented:-on 08/19/2025 old business included staffing concerns and staff on their cellphones. New business included missing items.-on 09/16/2025 old business included staff using cellphones in resident areas and missing items from resident rooms. New business included the President of the resident council asking when Administration was going to address their old business.-on 10/21/2025 new business included staffing concerns and staff on their phones in the dining room.-on 11/18/2025 old business included staff on their cellphones in the dining room marked as not resolved and staffing concerns marked as partially resolved. New business included an elevator does not work sign on the elevator.-on 12/16/2025 old business included the elevator does not work sign on the elevator not resolved.-on 01/20/2026 new business included a lack of nursing presence on the units, staff using their cellphones and earbuds during care, and Resident #17 missing several items of clothing. There was no documented evidence the new business or old business items were investigated, or rationales and responses were provided to the Resident Council during subsequent meetings.There was no documented Grievance/Missing Item form for Resident #17. During an interview on 02/10/2026 at 2:32 PM, the Director of Activities stated they and one other staff member were responsible for taking notes for the resident council. After the meeting, they sent out the minutes to all managers so they could address the concerns. They recently implemented a department response form that was now required to be filled out. Prior to the form, they spoke with the managers directly, discussed the issues in morning meetings, and at the bimonthly quality assurance meetings. Missing items reported in Resident Council went directly to the Director of Environmental Services. Most of the time, the (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Environmental Services was already aware of the missing items. The issue of staff being on their phones was brought to the attention of the Administrator, the Director of Nursing, and the Unit Managers. They were unaware of anything done to address the issue in an official capacity, but it was not addressed with the Resident Council. The elevator sign was on the third floor and was placed by staff to deter confused residents from the elevator, but it only worked to upset the alert and orientated residents and confuse visitors. The issue was resolved but it took a long time for the sign not to be put back up after being taken down. During an interview on 02/10/2026 at 2:51 PM, the Director of Social Work stated if a resident stated items were missing during Resident Council there was a form that was filled out and an investigation was conducted. Usually, the Activities Director would let them know if there were any complaints of missing items. They stated they had not been made aware Resident #17 had any missing items. 10 New York Codes, Rules and Regulations 415.5(c)(6)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure a safe, clean, comfortable, and homelike environment for one (1) of three (3) resident floors (Second floor) reviewed. Specifically, the Second floor hallway carpet was unclean with stains and dirt debris; room [ROOM NUMBER] smelled of urine; and room [ROOM NUMBER] D's bathroom had a broken light bulb. Findings include: The facility policy Building and Equipment Repairs Reporting, revised 02/02/2018, documented all personnel were informed about responsibilities for reporting malfunctioning equipment, damage to facility structure, or furniture or other items that needed repair. All new staff were educated on the procedure for reporting repairs needed and the safety and well-being of residents and staff were the responsibilities of all staff. Staff reported needed repairs via the electronic maintenance report system. Staff without access to email were to report the repairs needed to a supervisor. It was the responsibility of maintenance staff assigned to the location to monitor the requests.The facility policy Cleaning Occupied Resident Room, revised 10/12/2018, documented the room occupied by a resident was maintained in a clean, hygienic, and attractive state without disrupting resident health care, routines, or the privacy of the resident.Unclean floors:The following observations of the Second floor were made:-on 02/06/2026 at 9:16 AM the carpet outside resident rooms 231and 233 was visibly dirty. There were crumbs, dirt clumps and particles, small plastic tips and pieces of packaging on the floor.-on 02/06/2026 at 10:21 AM the carpet outside 214 had bread and/or cracker crumbs, string and visible dirt.-on 02/06/2026 at 11:05 the carpet in front of resident room [ROOM NUMBER] was had food crumbs, skin flakes, dirt and paper pieces.-on 02/06/2026 at 11:07 AM there was a medicine cup on the floor outside resident room [ROOM NUMBER], a plastic stopper along and paper on the floor between resident rooms [ROOM NUMBERS].-on 02/09/2026 at 3:19 PM the carpet between resident rooms [ROOM NUMBERS] had dirt, crumb debris and dark brownish-gray line stains. -on 02/09/2026 at 3:47 PM the carpet between resident room [ROOM NUMBER] and the housekeeping closet had visible debris, dirt, part of a plastic bag, little white pieces of paper, and an oblong brown dead bug. -on 02/09/2026 at 3:49 PM the carpet along the wall between resident rooms [ROOM NUMBERS] had visible food particles, built up dirt debris and white crumbs. During an interview on 02/10/2026 at 10:00 AM Certified Nurse Aide #35 stated housekeeping was on the floor every day and they cleaned both the residents' rooms and the hallways. It had been a while since the housekeeping staff vacuumed the carpet in the hallways. They used to vacuum every day but since the renovation occurred it no longer happened. Housekeeping walked around with a dustpan, but the broom did not do much for the overall floor. They stated the floors were dirty. During an interview on 02/10/2026 at 12:10 PM, Licensed Practical Nurse #32 stated housekeeping was on the floor every day. They stated they only vacuumed the hallways every once and a while. They stated if the floors were visibly dirty, they let housekeeping know. Nursing also had a dustpan and broom they were given to use. During an interview on 02/10/2026 at 11:13 AM the Director of Environmental Services stated the carpets in the hallway were spot cleaned several times a week and thoroughly cleaned a few times a year with carpet shampoo and extractors Resident rooms: During an observation on 02/09/2026 at 10:15 AM room [ROOM NUMBER]'s floor had white powder next to the bed, the room smelled of urine, and the bed was not made. During an interview on 02/05/2026 at 10:43 the family member of the resident in room [ROOM NUMBER] stated their only concern with the facility was how unclean the resident's room was. They stated they often had to get staff to come and clean the room as the room smelled like urine and the bed was unmade. They stated the resident urinated in the room, but they should not have to alert the staff because the room smelled, and the floor was sticky.During an interview on 02/10/2026 at 10:00 AM Certified Nurse Aide #35 stated if a resident's family complained about the cleanliness of a room, staff should (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	let housekeeping know as well as the licensed practical nurse and the Unit Manager. They stated if it was something they could clean they would. The family of the resident in room [ROOM NUMBER] complained about the cleanliness of the room. The resident urinated in their room; however, housekeeping was supposed to be paying more attention to the room since it was becoming more common. During an interview on 02/10/2026 at 11:13 AM the Director of Environmental Services stated rooms were cleaned daily and were deep cleaned upon discharge or a room transfer. Housekeeping staff should clean the floors and bathrooms, wipe high contact areas, and look for dust. The floors should not be sticky but heavily disinfecting a floor could make them tacky. A room where a resident had a habit of urinating was readdressed when there was an issue, but it was a hit or miss.During an observation and interview on 02/06/2026 at 9:37 AM the resident in room [ROOM NUMBER] D stated their bathroom light was out and had been out for two or three days. There was no other light in the bathroom unless the door was left open. The resident stated maintenance came to check it out and told them there was no bulb to replace the light.The electronic maintenance request system report documented requests were submitted for the bathroom light not working in room [ROOM NUMBER] D on 02/05/2026 at 11:00 AM, 02/06/2026 at 8:33 AM, and 02/06/2026 at 9:58 AM.During an interview on 02/06/2026 at 9:42 AM, Unit Clerk #39 stated work orders for the facility could be entered by anyone, but they generally entered them. Maintenance usually responded quickly to the maintenance requests. They were unaware of room [ROOM NUMBER] D's bathroom light being out and stated someone else must have put the work orders in.During an interview on 02/06/2026 at 9:57 AM Maintenance Assistance #38 stated they completed maintenance requests all over the building. They stated maintenance requests were submitted via the maintenance work order system or sometimes staff stopped them in the hallway with a request. Thet stated they were not out of bathroom light bulbs. They were unaware of who told the resident they did not have light bulbs for the bathroom.During an interview on 02/06/2026 at 10:29 AM, Certified Nurse Aide #35 stated the bathroom light in room [ROOM NUMBER] D was out for about 3 days. They were informed by maintenance there was no work order, but they personally entered two different work orders for the light. They informed the Unit Manager this morning when they saw the light was not replaced. They stated not having a bathroom light was not safe.During an interview on 02/10/2026 at 11:20 AM, the Maintenance Director stated work orders come through an automated work order system. The orders came directly to the electronic tablet the maintenance workers carried so they got alerts when there was a new order. When an order was completed, the maintenance worker put a note in on what they did and mark the order as completed. They stated they checked the status of orders through a report in the system. If a bathroom light was out, it would be a high priority issue that should be resolved in 30 minutes or less. They received a report of a light being out in a resident's bathroom, but they did not recall the day or how long it took to resolve the order, but it was not long.New York Code Rules and Regulations 415.29(j)(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews during the recertification survey, the facility failed to follow proper sanitation practices to prevent outbreak of illness in one (1) of one (1) main kitchen. Specifically, expired sanitizer testing strips were used to test sanitizer strength in the three-bay sink; and a cloth was used to dry dishes and silverware as they came out of the dish machine. Findings include:The facility policy Dishwashing, Drying, Proper Storage, revised 04/26/2019, documented soiled dishes, trays, glassware, and silverware would be washed and sanitized in the dish machine. The items would then be air-dried on the clean area counters of dish room and never dried with a cloth. A test of the sanitizing solution strength of the dish machine and the third compartment of the three-bay sink was conducted daily by the dietary services supervisor. Pots, pans, and large utensils used in cooking and holding food were washed and dried in the three-bay sink. The first bay contained detergent for soaking and scrubbing pans. The second bay contained water to rinse off the detergent and debris. The items were sanitized by immersion in the third bay of the sink for at least one minute in a quaternary solution. During an observation and interview on 02/06/2026 at 10:30 AM, Food Service Manager #5 demonstrated testing of the sanitizer strength in the three-bay sink. They stated they were responsible for testing the sanitizer strength three times a day using the test strips hanging near the three-bay sink. They took the test strip dispenser from where it was stored on the wall next to the sink, pulled the test strip from the dispenser, and tested the sanitizer strength in the sink. Food Service Director #6 looked at the strips and stated they expired in January of 2025. They were not aware the test strips expired. During an observation and interview on 02/06/2026 at 10:49 AM, Dietary Worker #9 was unloading dishes and silverware from the clean end of the dish machine. A white dish cloth was sitting on top of the clean silverware that had just come out on the machine. Dietary Worker #9 used the white cloth to wipe the silverware and plates. Dietary Worker #9 stated they used the cloth because the silverware and plates were wet. They demonstrated how they wiped everything off as they came out of the machine. They stated nobody taught them to do this, but they wanted to make sure the dishes were dry. During an interview on 02/09/2026 at 3:08 PM, Food Service Manager #5 stated they never checked the expiration date of the test strips and was not aware that they expired. They were not sure why the test strips would expire but thought expired test strips would not give accurate readings. During an interview on 02/09/2026 at 3:35 PM, Food Service Director #6 stated they never checked the expiration date of the test strips and was not aware that they expired. The expiration date indicated the test strips lost potency over time and once they expired would not read the sanitizer concentration correctly. They stated food service staff were trained to air dry items that were cleaned and sanitized in the dish machine. Using a cloth to dry dishes could cause cross contamination and spread germs to residents. 10 New York Codes, Rules and Regulations 415.14(h)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews, observations, and record review during the recertification survey, the facility failed to develop and implement a baseline care plan that included the minimum healthcare information necessary to properly care for a resident within 48 hours of their admission for one (1) of one (1) resident (Resident #97) reviewed. Specifically, Resident #97 was admitted from the hospital with an arm sling recommended by a specialist and there was no physician order or care plan for the use of the arm sling. Findings include:Resident #97 had diagnoses including a right upper arm fracture, osteoporosis, and right pelvic fracture. The 12/25/2025 admission Minimum Data Set assessment documented the resident was admitted from the hospital, had moderately impaired cognition, had impairments of one arm and leg, required maximal assistance with upper body dressing, was totally dependent on transfers, and did not receive training on a splint or brace.The 12/17/20205 hospital orthopedic consult documented the right upper arm was to be non-weight bearing and a sling was to be used. The 12/19/2025 physician orders did not include the use of a right arm sling. The 12/19/2025 baseline care plan documented the resident had a closed fracture of the right arm. Interventions included medications as ordered, education for safety precautions, monitor for skin changes/swelling, orthopedic consultations as needed, physical and occupational therapy evaluations and treatments per orders. There was no documented evidence of the use of a sling.The 12/19/2025 at 3:56 PM Nurse Practitioner #10 progress note documented the resident had a sling for the right arm. The 12/19/2025 at 7:05 PM Registered Nurse #11 admission progress note documented the resident was admitted from the hospital due to a right upper arm and pelvic fracture. There was no documented evidence of a right arm sling.The 12/23/2025 at 10:23 AM Physician #12 progress note documented the resident was to be non-weight bearing to the right arm and a sling was to be used. The resident had an orthopedic follow up appointment in two weeks.During an observation and interview on 02/02/2026 at 12:20 PM, Resident #97 was lying on their bed dressed and groomed. The resident had an arm sling between their right arm and the bed sheet. The sling was not supporting the upper arm. The resident stated they got the sling during their hospital stay after they fell and fractured their right arm.During an interview on 02/09/2026 at 12:07 PM, Registered Nurse Manager #4 stated a registered nurse was responsible for initially admitting a resident. They should read the hospital discharge summary, perform the resident assessment, and review the admitting orders. The admitting orders also included equipment recommendations including a sling. The baseline care plan was also initiated. They reviewed the resident records and stated the sling was on the discharge summary but there were no admitting orders or care plan for the sling and there should have been. The purpose of including the sling in the care plan was to ensure the resident received the proper care needed. During an interview on 02/09/2026 at 12:26 PM, Certified Nurse Aide #13 stated resident specific care was documented in the care instructions that the aides reviewed prior to providing a resident care. The care instructions were populated by the care plan. They stated they were aware the resident used a right arm sling because they saw it on the resident numerous times. The resident wore the sling as they wanted and sometimes they took it off by themselves. Staff should make the nurse manager or supervisor aware if equipment was not in the care instructions and they did not remember if they told a supervisor.During an interview on 02/10/2026 at 12:13 PM, the Director of Rehabilitation stated the initial therapist was supposed to put in the care plans activities of daily living which included mobility status and any assistive devices. A sling was not considered an assistive device but should have been in the care plan. If a resident was non-weight bearing for an arm, they should be wearing the sling. If a sling was ordered from the hospital, it should be documented in the care plan, so staff were aware of its use. After reviewing the resident's chart, they stated they did not see an order or care plan for the resident to use a sling and there should have been both. 10 New York Codes, Rules and Regulations 415.11(c)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and promote healing of pressure ulcers for one (1) of three (3) residents (Residents #16) reviewed. Specifically, Resident #16's wound care was not completed as ordered and a vascular consult was not ordered as recommended by the wound care provider. Findings include: The facility policy, Pressure Ulcer, Pressure Injury, and Other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation, and Management, revised 02/27/2023, documented residents with pressure ulcers, injuries, or skin conditions received timely assessments, evaluation, treatment, and services to promote healing, prevent infection, and prevent new conditions from developing. Ongoing assessments of existing pressure ulcers, injuries, and other skin conditions were to be conducted weekly by facility staff and/or a consultant who specialized in wound management. Progress, treatments, and care plan interventions were to be reviewed at that time and documented in the medical record. Wound consultant progress notes were to be scanned into the medical record.Resident #16 had diagnoses including weakness, hypertension and dementia with agitation. The 12/03/2025 Minimum Data Set documented the resident had intact cognition, was independent for most activities of daily living, was at risk of developing pressure ulcers, had a Stage 3 pressure ulcer (full thickness tissue loss), had pressure reducing devices to the bed and chair and applications of dressings to their feet.The 06/13/2025 Comprehensive Care Plan, revised 12/22/2025, documented the resident had an alteration in skin integrity related to an unstageable pressure ulcer located on the left heel. Interventions included applying the treatment per order and assessing and documenting the status of the pressure ulcer weekly. The 01/16/2026 Skin and Wound Note by Wound Consultant Nurse Practitioner #19 documented the resident was being followed for an unstageable pressure ulcer on their left heel. The wound healing had stalled. Complications to wound healing included intermittent noncompliance with their compression wraps. The staff reported the resident ambulated unassisted despite staff instruction and they had to remove the resident's heel boot to prevent falls. Nurse Practitioner #19 discussed with the staff to obtain a vascular consult due to the stalled nature of wound, if the family agreed. The treatment was changed to betadine (antiseptic) moistened gauze since peri-wound (outside) was macerated (softening due to moisture).The 01/17/2026 physician order documented to cleanse the wound on the left heel with wound cleanser, apply betadine moistened gauze and cover with a border gauze. The 01/30/2026 Skin and Wound Note by Wound Consultant Nurse Practitioner #19 documented the resident was being followed for an unstageable pressure wound on their left heel. The staff reported the resident ambulated unassisted despite staff instruction and they had to remove the resident's heel boot to prevent falls. The assessment and plan was to continue with the heel boot to the left foot when out of bed and in the wheelchair, continue the compression wraps, and to continue betadine moistened gauze treatment.There were no physician orders or any documentation in the comprehensive care plan related to the left heel boot or the compression wraps. There was no documented evidence of any follow up related to the wound consultant's recommendation of a vascular consult. Resident #16 was observed on:- 02/05/2026 at 9:35 AM walking to the room door without an assistive device. The resident then sat down in the wheelchair with slightly elevated leg rests. They did not have on heel boots or compression wraps.- 02/06/2026 at 11:15 AM sitting up in their wheelchair in their room with their feet in the slightly elevated leg rests with their heels off the back of the foot pedals. The resident had non-skid socks, but no compression wraps or a left heel boot.- 02/09/2026 3:27 PM the resident was sitting in their wheelchair with non-skid socks on with no heel boot on their left foot or compression wraps. At 3:35 PM, following their wound care being completed, they were sitting in their wheelchair and the resident asked about their compression wraps and if they needed them applied.TREATMENT OMISSIONS: The 02/2026 Treatment Administration record documented the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following treatment orders: -to right heel apply skin prep wipe (skin protectant) topically every day and evening shift with a start date of 08/26/2025.-to unstageable left heal cleanse with wound cleanser, apply betadine (topical antiseptic) moistened gauze, cover with border gauze every day shift with a start date of 01/17/2026. There was no documented evidence the treatments were administered on the 02/01/2026, 02/05/2026, and 02/06/2026 day shifts. During an interview on 02/10/2026 at 10:37 AM Licensed Practical Nurse #30 stated they knew how to care for a resident by their care plan. Interventions for pressures ulcers were on a resident's care plan as well as in the Treatment Administration Record. A resident who needed a heel boot would have an order on the Medication Administration Record. Resident #16 did not have to wear heel boots, but they did have compression wraps that were supposed to be applied during day shift. Wound care ordered on their shift should be completed on that shift. If the wound care was unable to be completed, they were to inform the oncoming nurse. Sometimes when they had to split the floor between two nurses instead of three, treatments did not get done. If a wound care treatment was not documented on the Treatment Administration Record, it was not done. They were unsure if they completed the wound care treatment on Resident #16 on 2/1/2026 or 2/6/2026 but if it was not documented, they didn't do it.During an interview on 02/10/2026 at 11:48 AM Certified Nurse Aide #31 stated they knew how to care for a resident by their care plan. Any interventions for pressure ulcers were on the resident's care plan, including if heel boots needed to be applied. They checked the care plan daily. They believed Resident #16 had to wear a heel boot on their left foot while in bed and when the resident was cooperative.During an interview on 02/10/2026 at 12:10 PM Licensed Practical Nurse #32 stated interventions for a resident with a pressure ulcer were on their care plan. A resident who needed to wear heel boots would have an order. Resident #16 could use a heel boot for their pressure ulcer, but they got up at night when it was applied so it was a safety issue. If an intervention did not work, they would notify the provider. A wound care treatment ordered for their shift was to be completed on that shift and documented as completed in the Treatment Administration Record. If a treatment was not documented on the Treatment Administration Record, it meant it was not done. They stated they had completed Resident #16's wound care treatment on 02/05/2026 but there were only two nurses on the hall that day so the documentation may have been missed.During an interview on 02/10/2026 at 12:23 PM Licensed Practical Nurse Unit Manager #18 documented they updated the care plans in collaboration with the Assistant Director of Nursing #33 and the Director of Nursing. Wound rounds are done weekly with the Assistant Director of Nursing. The recommendations from the wound care provider were given to Assistant Director of Nursing #33. The Assistant Director of Nursing #33 then gave the recommendations to them, and they communicated with the provider regarding the recommendations. The recommendations for preventative equipment are put into place if it was determined safe. The provider was notified if an intervention did not work. Resident #16 was ambulatory, and a left heel boot was a safety boot while the resident was in bed. The resident did have a left heel boot, and compression wraps at one time but no longer had orders for either. They would have to clarify the recommendations and orders with the facility providers and the wound care provider since they were in the providers' notes regarding the wound treatment plan. They were unaware the wound care provider had recommended the resident to have a vascular consult, and they did not know why it had not been taken care of.During a phone interview on 02/10/2026 at 1:20 PM Nurse Practitioner #28 stated they were given the recommendations from the wound care provider by Licensed Practical Nurse Manager #18. If there were new orders or intervention recommendations, Licensed Practical Nurse Manager #18 put the orders in under their name for them to electronically sign. If a recommendation is not effective, like a heel boot, they were notified. If the wound care provider was recommending compression wraps or a left heel boot, they would need to reorder those. If the concern was safety while ambulating, the order may need to be adjusted instead of just discontinuing the order. They believe they would be notified if a wound was reclassified but they do look at the wound themselves and there may be a difference in opinion. From their opinion Resident (continued on next page)

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	335678	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Liverpool	4800 Bear Road Liverpool, NY 13088

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#16 had a stage 3 pressure ulcer on their left heel but they did believe their documentation had to be consistent with the wound care provider.During a phone interview on 02/10/2026 at 1:59 PM Wound Care Nurse Practitioner #19 stated the recommendations they give to the facility got to Assistant Director of Nursing #33. They stated Resident #16 could be intermittently non-compliant. The staff stated the left heel boots didn't work but they still recommended them because they could help with the resident's wound healing. If at the time, it was not safe to put the heel boot on that day, it was fine, but it was better to have the boots recommended and used when the resident was compliant than not at all. They were unsure how often the staff put the compression wraps on the resident, but it was a recommendation they always made when the resident was compliant as the resident's legs were mostly dependent all day. They expected the facility to follow their recommendations regarding wound care and interventions. They expected the staff to continuously reassess the interventions day to day to try and get the wound to heal. 10 NYCRR 415.12(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review, and interviews, the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional standards for one (1) of four (4) medication carts (1st floor North medication cart). Specifically, the 1st floor North medication cart contained an opened lidocaine (anesthetic) vial and opened insulin pens with no documented opened dates.Findings include: The facility policy Medications Administration Methods, revised 01/25/2024 documented responsible staff would pass medications according to techniques and practices in compliance with New York State rules and regulations, and current practice standards. Medication expiration dates were to be checked prior to administration. Refer to manufacturer's guidelines for medications with shortened expiration such as insulin.During a 1st floor North medication cart storage review on 02/05/2026 at 2:55 PM with Licensed Practical Nurse #3, the following was observed in the top drawer of the medication cart:- an opened vial of lidocaine 1% (anesthetic) with no opened date. - an opened Resident #185's glargine (insulin) pen with no opened date. - an opened Resident #21's Lantus (insulin) Solostar pen with no opened date. During an interview on 02/05/2026 at 3:18 PM, Licensed Practical Nurse #3 stated the nurse opening the insulin pen or vial was supposed to write the open date and their initials on it. Any nurse administering the medication should check for the expiration and open dates prior to giving the medication. They were not sure who else was responsible for checking for expired medications on a routine basis in the medication carts or rooms. They stated if an insulin pen or vial did not have an open date written on it, it was considered expired, should not be given, and discarded. Licensed Practical Nurse #3 stated they did not give those medications today.During an interview on 02/10/2026 at 12:39 PM, Registered Nurse Manager #4 stated each medication nurse should check expiration dates of all medications in the medication cart and medication room every shift. The nurse opening an insulin pen and vial should document on the medication the date they opened it. They stated insulin pens and vials were only good for 30 days after the open date and should be discarded after 30 days. The undated insulin pens and vial were considered expired as there was no way to know when they were opened. 10 New York Codes, Rules and Regulations 415.18(d)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interviews during the recertification survey, the facility failed to ensure garbage and refuse was disposed of properly for one (1) of one (1) dumpster observed. Specifically, the area around the dumpster located outside near the kitchen was not maintained to prevent attraction and harborage of pests. Findings include:The facility Assistant Dining Services Manager Evening Checklist procedure form, dated 09/2002, documented food service would observe the dumpster area in the evening to check for food debris and ensure the dumpster lids were closed. During an observation on 02/06/2026 at 11:00 AM, the dumpster located outside the kitchen, had food debris, food wrappers, and used gloves around the dumpster and near the fence that surrounded the dumpster area. During an interview on 02/09/2026 at 3:08 PM, Food Service Manager #5 stated the area around the dumpster should be free of food debris and garbage to prevent rodents and for sanitation. During an interview on 02/09/2026 at 3:35 PM, Food Service Director #6 stated the area around the dumpster should be free of food debris and garbage to prevent rodents. They used the dumpsters for food waste, food packaging waste, and cardboard. They did not know who was responsible for maintaining the cleanliness of the area but stated it was either maintenance or housekeeping, and if any food service garbage needed to be cleaned up, they received a call from one of those departments. During an interview on 02/10/2026 at 10:45 AM, Housekeeping Director #7 stated they used the dumpsters for cardboard and waste. They looked around the dumpster areas for cleanliness a few times a week and whenever they were out in that area. Food service, housekeeping, and maintenance all worked together to monitor the area but not one department was primarily responsible for the area. Whoever had trash on the ground was responsible for cleaning it up. During an interview on 02/10/2026 at 10:50 AM, Maintenance Director #8 stated their department used the dumpsters for cardboard and was responsible for clearing snow around the dumpster area. No specific department was primarily responsible for monitoring the area by the dumpsters, it was a team effort between maintenance, housekeeping and dietary. During an interview on 02/10/2026 at 3:51 PM, Director of Nursing #2 stated the facility did not have a specific policy on dumpster maintenance. 10 New York Codes, Rules, and Regulations 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews during the recertification survey the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) of four (4) residents (Resident #48) reviewed. Specifically, Resident #48 was on transmission-based precautions (contact precautions) and Registered Nurse #16 was observed not wearing appropriate personal protective equipment while administering medications or practicing hand hygiene to prevent the spread of infection.Findings include:The facility policy Transmission Based Precaution Levels, last reviewed 06/06/2024, documented standard precautions were based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes could contain transmissible infectious agents. Standard precautions include a group of infection prevention practices that would apply to all residents, regardless of suspected or confirmed infection status, in the healthcare setting that would include use of gloves, gown, mask, eye protection or face shield, depending on the anticipated exposure. Contact precautions would be used for residents who were known or suspected of having a serious illness easily transmitted by direct resident contact or by contact with items in the resident's environment.Resident #48 had diagnoses including multidrug-resistant organism (bacteria that developed resistance to certain antibiotics). The 02/04/2026 Minimum Data Set (an assessment tool) documented the resident was cognitively intact, frequently incontinent or urine and stool, required supervision or touching assistance with toileting hygiene, and partial/moderate assistance with personal hygiene and bed mobility.The undated facility provided list of residents on contact precautions with active clostridioides difficile (highly contagious bacteria that causes diarrhea) included Resident #48.The 02/05/2026 physician order documented maintain clostridioides difficile (C-diff) contact precautions, resident to remain in the room and be provided services in the room.The certified nurse aide care instructions documented the resident was frequently incontinent of stool and had loose stools from 02/04/2026-02/09/2026.During an observation on 02/09/2026 at 10:17 AM, Resident #48 had a contact precaution sign posted outside their room. Registered Nurse #16 was at the resident's bedside administering eye drops, an inhaler, and other medications in applesauce while wearing gloves and a mask. At 10:19 AM, Registered Nurse #16 picked up an unused pain patch and the eye drop and inhaler boxes from the resident's bedside table while wearing the same gloves, walked out of the room and placed the unused pain patch and boxes on top of the medication cart. They removed their gloves and cleaned their hands with hand sanitizer before documenting in the electronic medical record. Registered Nurse #16 did not perform appropriate hand hygiene for clostridioides difficile.During an interview on 02/09/2026 at 10:21 AM, Registered Nurse #16 stated Resident #48 was on contact precautions for clostridioides difficile which meant staff were required to wear a gown, mask, and gloves in the room and wash their hands using soap and water to prevent the spread of infection. They did not follow the contact precautions because they did not see the sign when they went into the room. They stated they cleaned their hands with hand sanitizer after exiting the room but was going to go wash their hands with soap and water because hand sanitizer was not effective against clostridioides difficile.During an interview on 02/10/2026 at 12:23 PM, Licensed Practical Nurse Manager #18 stated when a resident was on precautions it was communicated to staff during nurse-to-nurse report. All staff received infection control education annually and they had monthly unit meetings with staff that included infection control education. Resident #48 was on contact precautions for clostridioides difficile, so staff were required to wear a gown, gloves, and mask while in the room. The medication boxes should not have been brought into the room. Because the medications and the boxes were brought into the room they should have been wiped down with cleaning wipes and air dried before going back into the medication cart. Registered Nurse #16 should not have left Resident #48's room wearing dirty gloves and they should have (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	washed their hands with soap and water before touching anything else.During an interview on 02/10/2026 at 01:47 PM, Assistant Director of Nursing/Infection Preventionist #17 stated infection control education was ongoing all the time and staff were educated on transmission-based precautions annually and as needed. They completed weekly audits for residents on transmission-based precautions to ensure they had physician orders, care plans, precaution signage outside the room, personal protective equipment was available, and staff were wearing appropriate personal protective equipment in the resident's room. Staff were required to wear a gown, gloves, and a mask in a contact precaution room. Resident #48 was on contact precautions for clostridioides difficile. Medication boxes should not be brought in or set down inside the resident's room and the medications should have been placed inside a plastic bag before they were put back into the medication cart. Registered Nurse #16 should not have touched anything outside the room without washing their hands with soap and water because hand sanitizer was not effective at killing the bacteria and it was extremely contagious.10 New York Codes, Rules and Regulations 415.19(a)(b)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interviews during the recertification survey, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for one (1) of three (3) residents (Resident #208) reviewed. Specifically, Resident #208 remained in the facility after discontinuation of Medicare Part A, and the facility did not provide a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (Centers for Medicare and Medicaid Services-10055) for Medicare Part A as required.Findings include: The instructions for the Center for Medicare and Medicaid Services Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services form 10055, documented a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage form 10055 must be issued by providers to beneficiaries in situations where Medicare payment was expected to be denied. The Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage must be delivered far enough in advance that the beneficiary or the representative had time to consider the options and make an informed choice prior to services ending.Resident #208 had a Medicare Part A skilled services episode start date of 6/30/2025 with a last covered day of Part A services of 09/01/2025.The Notice of Medicare Non-Coverage for Centers for Medicare and Medicaid Services-10123 letter documented Resident #208's episode start date of 6/30/2025 and the effective end date of services was 09/01/2025. The handwritten note on the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage documented the Center for Medicare and Medicaid Services Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services form 10055 was not signed by Resident #208's Power of Attorney on 10/03/2025.During an interview on 02/09/2026 at 12:15 PM, Business Office Manager #40 stated they were familiar with the Advance Beneficiary Notice of Non-coverage and knew it should have been provided to the residents at least two days prior to the start of non-coverage but it was not. They stated it took time for the family to finally decide what they were going to do regarding Resident #208's continued stay in the facility. Business Office Manager #40 stated that if the Advance Beneficiary Notice of Non-Coverage advance notice was not given to the resident or their representative, the resident would not know their financial liability and therefore could be financially liable for non-covered services received. 10 New York Code Rules and Regulations 483.10 (g) (18)