STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335679	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Hamburg	5775 Maelou Drive Hamburg, NY 14075

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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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 #2596250), the facility did not ensure that all alleged abuse violations were reported immediately but not later than 2-hours after the allegation was made to the Administrator of the facility and to the State Survey Agency for one (1) (Residents #1) of three (3) residents reviewed. Specifically, staff failed to 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 dementia, depression, and hypertension. The Minimum Data Set (a resident assessment tool) dated 06/20/2025 documented Resident #1 was severely, cognitively impaired, was rarely/never understood and rarely/never understands.The comprehensive care plan revised on 07/11/2025 documented that Resident #1 had severe cognition, required assistance with activities of daily living, and had limited physical mobility. 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 8/9/2025 at 7:32 AM. The date/time the Administrator was first made aware of the incident was 8/20/2025 at 2:00 PM. It was submitted by the facility to the New York State Department of Health on 8/20/2025 at 3:17 PM.The facility accident/incident dated 8/20/2025 at 2:00 PM documented a potential altercation between a staff member and resident occurred at some point last week in the afternoon between (lunch and 3:00 PM). Licensed Practical Nurse #1 was told that an employee slapped Resident #1 in the back of their head. The alleged abuse occurred on 8/9/2025 at 7:32 AM based on review of the facility's camera footage.During an observation on 8/27/2025 at 9:42 AM, Resident #1 was seated in their wheelchair across from the third-floor nurse's station. They were alert and oriented to self only and were unable to be interviewed. During an interview on 8/27/2025 at 9:50 AM, Certified Nurse Aide #1 stated they witnessed Certified Nurse Aide #2 slap Resident #1 on top of the head when they were sleeping in their wheelchair sometime within the last few weeks between 11:30 AM and 1:00 PM. Certified Nurse Aide #1 stated they reported incident to Licensed Practical Nurse #1 on 8/20/2025. Certified Nurse Aide #1 stated they knew they should have reported the slap immediately, but they were afraid of retaliation from Certified Nurse Aide #2. Review of the facility's camera footage in the presence of the Director of Nursing and Certified Nurse Aide #1 of the alleged incident dated 8/9/2025 at 7:32 AM as reported to the Department of Health on 8/20/2025 revealed Certified Nurse Aide #2 slightly tap Resident #1 in the back and on top of the head. During an interview on 8/27/2025 at 1:15 PM, the Director of Nursing stated that Certified Nurse Aide #1 should have reported the suspected abuse immediately on 8/9/2025 to the nurse. The incident was reported eleven days later. During an interview on 8/27/2025 at 2:10 PM, Registered Nurse Unit Manager #2 stated abuse allegations had to be reported within a two-hour time frame from the occurrence. Certified Nurse Aide #1 should have reported the abuse to the Supervisor on 8/9/2025. Waiting over one week was too long. During a telephone interview on 8/27/2025 at 2:16 PM, Certified Nurse Aide #2 denied slapping Resident #1 in the back of their head and stated slapping a resident would be physical abuse. During a telephone interview on 8/28/2025 at 10:28 AM, Licensed Practical Nurse #1 stated Certified Nurse Aide #1 reported to them on 8/20/2025 at 2:00 PM that they had witnessed Certified Nurse Aide #2 slap Resident #1 in the back of the head, and that Certified Nurse Aide #1 was uncertain of the day and time that it had occurred. Licensed Practical Nurse #1 stated they reported the allegation of abuse immediately to the Director of Nursing on 8/20/2025. During a telephone interview on 8/28/2025 at 1:15 PM, the Administrator stated Certified Nurse Aide #1 should have reported the suspected abuse immediately on 8/9/2025 after witnessing Certified Nurse Aide #2 slap Resident #1. The delay in reporting was unacceptable. 10 NYCRR 415.4 (b)(2)