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	01/22/2026

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review conducted during the survey, the facility did not ensure that services were provided to meet professional standards of quality care for one (1) (Resident #3) of six (6) residents reviewed. Specifically, Resident #3 did not receive all their evening medications as ordered by the medical provider, the nursing supervisor and medical provider were not notified of the omissions, and the Licensed Practical Nurse documented the medications were administered. The finding is: The policy titled Medications Administration Methods dated 01/25/2024, documented medication administration must be documented on the Medication Administration Record/Electronic Medication Administration Record immediately before going on to the next resident. The nurse will indicate if the medication was withheld or refused. Reasons are recorded on the Medication Administration Record/Electronic Medication Administration Record. The policy documented all problems related to medication are noted and later reported to unit manager/supervisor. The policy titled Notification of Resident Changes dated 03/29/2018, documented the facility would immediately inform the resident and consult with the resident's physician if a need to alter treatment significantly. The facility's Licensed Practical Nurse Team leader job description revised January 2026 documented essential job functions would consist of administering medications and treatments to assigned residents as ordered by physician and utilizing the five (5) rights as applicable. The job description documented the licensed practical nurse will perform timely and accurate documentation according to the service excellence standards and goals established for the position. The licensed practical nurse will contact the medical doctor/nurse practitioner/physician assistant for orders or updates according to the resident response to treatment plan and/or situation. Resident #3 had diagnoses that included anxiety disorder, major depression disorder, and schizophrenia. The Minimum Data Set (a resident assessment tool) dated 10/03/2025 documented Resident #3 was cognitively intact, understood and understands. The comprehensive care plan dated 01/30/2024, documented Resident #3 was independent with decision making and had potential for bleeding due to the resident being on anticoagulant therapy related to history of pulmonary embolism (blood clot in the lungs) and transient ischemic attack (temporary blockage of blood flow to the brain) with interventions to administer medications as ordered and monitor for side effects. Resident #3 was used psychotropic medications due to depression, anxiety and tardive dyskinesia (a movement disorder caused by a long-term use of antipsychotics) and fibromyalgia (disorder with widespread muscle pain). Interventions included administering medications as medical doctor/nurse practitioner ordered, monitor effectiveness and update medical doctor/nurse practitioner on residents' status as needed. Review of the iQIES (Internet Quality Improvement and Evaluation System) complaint/incident investigation report, facility reported incident #2664370, dated 11/10/2025, the Director of Nursing documented that Resident #3 reported that on 11/07/2025 Licensed Practical Nurse #3 did not administer their bedtime medications because the pharmacy had not delivered them yet. The Director of Nursing documented that Resident #3 was claiming their tardive dyskinesia is acting up (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because they did not get their medications. Review of a statement dated 11/08/2025, provided as part of the facility's investigation, Licensed Practical Nurse #6 documented that they obtained a verbal statement from Licensed Practical Nurse #3 who stated that Resident #3's evening medications on 11/07/2025 were not available, but they did administer the narcotics and stock medications. Licensed Practical Nurse #3 stated they later became aware the Resident #3's next week supply of medication was available and assumed the next nurse (Licensed Practical Nurse #4) would administer them. Review of an electronic mail conversation message thread dated 11/10/2025 and 11/11/2025, provided by the facility as part of their investigation, the Assistant Director of Nursing responded to the Administrator request to interview Licensed Practical Nurse #4 regarding Resident #3's evening medications not being administered. The Assistant Director of Nursing documented Licensed Practical Nurse #4 stated they were never notified by Licensed Practical Nurse #3 that Resident #3's evening medications were not administered. Licensed Practical Nurse #4 stated that Licensed Practical Nurse #3 found the medication in the medication room in the cycle tote. Review of an undated statement, provided by the facility as part of their investigation, Licensed Practical Nurse #5 documented Resident #3 told them they did not receive their evening medications the previous night. Licensed Practical Nurse #5 documented there were no evening medications in the drawer on Friday day shift and there were no evening medications missing from future medication packs. Review of a statement dated 11/11/2025 at noon, the Director of Nursing documented they performed a telephone interview with Licensed Practical Nurse #3 regarding Resident #3's evening medication pass. It was documented that Licensed Practical Nurse #3 stated Licensed Practical Nurse #4 showed them where Resident #3's medications were in the medication room when they came into work (at shift change). It was documented that Licensed Practical Nurse #3 stated they had already counted out and thought Licensed Practical Nurse #4 would give the medications since they knew Resident #3 had not had them yet. When Licensed Practical Nurse #3 was asked why the medications were signed as administered, they replied I was tired and did not even think about it. Review of the electronic Medication Administration Record dated 11/01/2025-11/30/2025 revealed the following medications were to be administered to Resident #3 at bedtime on 11/07/2025:Buspirone 10mg (antianxiety)Caplyta 21 mg (antidepressant)Eliquis 5mg (blood thinner)Floranex one tab (probiotic)Lipitor 40mg (cholesterol)Lyrica 75mg (narcotic analgesic)Oxycodone 10mg (narcotic analgesic)Polyethylene glycol 17 mg (laxative)Senna S one tab (laxative)Simethicone one tab (antiflatulent)Topiramate 25 mg (migraine prevention)Valbenazine 80mg (medication to lessen tardive dyskinesia symptoms)Zyrtec 10mg (congestion)Licensed Practical Nurse #3 signed the above medications as administered on 11/07/2025. Review of the facility's house stock formulary dated 12/2024 revealed Floranex, Polyethylene glycol, Senna S and Simethicone were listed as facility stock medications. Review of the Progress Notes dated 11/07/2025-11/30/2025 revealed no documented evidence that Resident #3's bedtime medications on 11/07/2025 were unavailable and that the nursing supervisor or medical provider were notified for new orders. On 11/08/2025 at 10:49 AM, the Director of Nursing documented they saw Resident #3 for complaints of increased tardive dyskinesia symptoms. They documented no increased facial movement or exacerbation of tardive dyskinesia was observed. During an observation and interview on 01/21/2026 at 2:18 PM, Resident #3 stated there was an evening sometime in November when the nurse did not administer all their evening medications. Resident #3 stated they do not remember why the nurse did not give them all their medications, but the staff member no longer worked for the facility. Resident #3 stated they were upset they did not get their medications and wondered if the incident would happen again. Resident #3 stated they have not had a problem with medication administration since then. Telephone interviews were attempted on 01/20/2026 at 3:43 PM and 5:19 PM, on 01/21/2026 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 2:21 PM, and on 01/22/2026 at 2:39 PM with Licensed Practical Nurse #3 without success. During a telephone interview on 01/20/2026 at 3:45 PM, Licensed Practical Nurse #4 stated on 11/07/2025 they relieved Licensed Practical Nurse #3 at 11:00 PM. Licensed Practical Nurse #4 stated they entered the medication room for the narcotic key exchange with Licensed Practical Nurse #3 and they noticed the seven (7) day supply of medication pill packs (medications from pharmacy sorted by date and time for administration and placed into sealed packets) were still in the medication room and had not been placed into the medication cart for the new week that started the next day. Licensed Practical Nurse #4 stated that when they remarked that no one put the pill packs into the medication cart, Licensed Practical Nurse #3 response was that they did not know what the pill packs were. Licensed Practical Nurse #4 stated Licensed Practical Nurse #3 never informed them that Resident #3's evening medications were unavailable and never asked them to administer Resident #3's evening medications from the following day's evening supply. Licensed Practical Nurse #4 stated they were asked to give a statement about the situation on 11/08/2025 and that was when they found out that not all of Resident #3's evening medications were given. Licensed Practical Nurse #4 stated all of Resident #3's evening medications on 11/07/2025 were signed as administered by Licensed Practical Nurse #3. Licensed Practical Nurse #4 stated the importance of administering medications as prescribed was because the medical provider prescribed them for something that was going on with the resident and it was the nurse's duty to administer them. During a telephone interview on 01/21/2026 at 12:31 PM, the Medical Doctor #1 stated they do not recall being notified that Resident #3 was omitted some of their evening medications in November 2025. They stated that if Resident #3's medications were unavailable they would have expected to be notified for new orders and the situation be documented in the electronic medical record. Medical Doctor #1 stated they would not expect medications to be documented as given if they were not administered. Medical Doctor #1 stated they were familiar with Resident #3, and they did not believe the resident was having any medical issues in November including any increase in their tardive dyskinesia symptoms. During a telephone interview on 01/21/2026 at 2:54 PM, the Pharmacy Consultant stated they were unsure if they were notified in November 2025 that Resident #3 had some of their evening medications omitted. They stated the facility's pharmacy provided the facility a 7-day supply of pill packs on a weekly basis. The Pharmacy Consultant stated their expectation for any unavailable medications was that staff notify the medical provider for any new orders. They stated that staff members should not sign off that medications were given if they were not administered because that staff member was not following proper policy and procedure and the facility could not determine if the medications were given or not. During an interview on 01/21/2026 at 3:41 PM, Registered Nurse #4, Unit Manager, stated Resident #3 reported a nurse did not administrator all their evening medications a few months ago and the facility did an investigation. Registered Nurse #4 stated Resident #3 stated because of their omitted medications their tardive dyskinesia symptoms were worse. Registered Nurse #4 stated they did not observe any increased symptoms in Resident #3. Registered Nurse #4 stated if the medications were unavailable, Licensed Practical Nurse #3 should have notified the nursing supervisor. They stated they do not believe Licensed Practical Nurse #3 notified the supervisor, the pharmacy or the medical provider and if they did, then it should have been documented in the electronic medical record. Registered Nurse #4 stated Licensed Practical Nurse #3 should not have documented Resident #3's evening medications as given because that would be false documentation. During a telephone interview on 01/22/2026 at 11:07 AM, Licensed Practical Nurse #1, Nursing Supervisor, stated they were the building supervisor working 11/07/25 into 11/08/25 on the 6:00 PM- 7:00 AM shift. Licensed Practical Nurse #1 stated Licensed Practical Nurse #3 did not notify them that (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's evening medications were unavailable. Licensed Practical Nurse #1 stated Licensed Practical Nurse #3 should have notified them immediately and they would have attempted to remove any medications they could from the emergency medication supply, contacted the pharmacy for an extra delivery and notified the medical provider for any new orders. During an interview on 01/22/2026 at 2:58 PM, the Director of Nursing stated they were notified that Licensed Practical Nurse #3 did not administer all of Resident #3's evening medications on 11/07/2025. The Director of Nursing stated Licensed Practical Nurse #3 documented all of Resident #3 evening medications were administered on 11/07/025 when they were not. They stated when Licensed Practical Nurse #3 was interviewed they admitted they only administered Resident #3's narcotics and stock medications because the other evening medications were not in the medication cart. The Director of Nursing stated Licensed Practical Nurse #3 never told the nursing supervisor and therefore the pharmacy was not contacted for an extra delivery nor was a medical provider notified. The Director of Nursing stated professional standards were not followed and Licensed Practical Nurse #3 was no longer employed at the facility. During an interview on 01/22/2026 at 3:11 PM, the Administrator stated they were aware Resident #3 did not receive all their evening medications in November 2025. The Administrator stated Licensed Practical Nurse #3 believed they did not have Resident #3's medications available to administer and Licensed Practical Nurse #3 never notified the nursing supervisor. The Administrator stated that Licensed Practical Nurse #3 was made aware by Licensed Practical Nurse #4 that there was a new weekly supply of medications in the medication room. They stated Licensed Practical Nurse #3 made an assumption that Licensed Practical Nurse #4 would administer Resident #3's evening medications but the two nurses did not have clear communication on who was administering Resident #3's medication. The Administrator stated the Licensed Practical Nurse #3 also documented all of Resident #3's evening medications as administered. The Administrator stated Licensed Practical Nurse #3 received their final disciplinary action through this issue and was no longer employee by the facility. They stated professional standards were not met in this incident. 10NYCRR 415.11(c)(3)(i)

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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 interview and record review conducted during the survey, the facility failed to ensure that each resident received adequate supervision and assistive devices to prevent accidents for two (2) (Resident's #1 and #2) of ten (10) residents reviewed for accidents. Specifically, facility staff failed to implement safety measures during resident repositioning. Residents were not provided with the assistance of two (2) staff members during bed mobility as planned and the bed locking systems were unlocked. Resident #1 fell from the bed sustaining a right elbow injury later identified as a fracture (broken bone) and Resident #2 fell from bed and sustained a fracture of their left middle finger and multiple lacerations (cut that goes through more than one (1) layer of skin caused by trauma) to their head, face and arm. This resulted in actual harm to Resident's #1 and #2 that is not Immediate Jeopardy. The findings are: The policy and procedure titled Prevention and Reporting of Accidents and Incidents for Residents dated 09/07/2023 documented that an accident was defined as an unexpected or unintentional incident, which may result in injury to a resident. This does not include adverse outcomes that were a direct consequence of treatment or care that was provided in accordance with current standards of practice. A fall was defined as an unintentional change in position coming to rest on the ground, floor or onto the next lower surface. The interdisciplinary team conducts a thorough resident assessment/evaluation to identify potential risk factors. Appropriate interventions are implemented to promote a safe environment. Interventions included, but were not limited to, adequate supervision; assistive devices; staff/resident education. The Director of Nursing Services/Nursing Supervisor will complete a resident description. The resident is approached immediately for an account of the accident/incident and if the resident was able and wishes to comment, the resident's response was recorded. The User-Service Manual for Bed Frames and Easy-Care Beds dated 2023 documented a warning: Before leaving the bed unattended, check that the Care Lock feature was in the locked position. Never leave an unlocked bed unattended and check that the Care lock feature was in the locked position before allowing the resident to enter or exit the bed. For best practices, the Care-Lock feature should be locked at all times, except when the bed was being moved. 1. Resident #1 had diagnoses that included a right below the knee amputation (surgical removal of a limb or part of an extremity), diabetes mellitus (a chronic condition characterized by high blood sugar resulting from the body's inability to produce or properly use insulin), and muscle weakness. The Minimum Data Set (a resident assessment tool) dated 08/15/2025 documented Resident #1 was cognitively intact. Resident #1 was dependent on staff for toileting and required substantial/maximal assistance for rolling left and right. The Comprehensive Care Plan dated 08/12/2025 documented Resident #1 required maximal/substantial assistance of two (2) staff members to roll left and right in bed. The Kardex Report (a guide used by staff to provide care) dated 08/15/2025 documented Resident #1 required maximal/substantial assistance of two (2) staff members to roll left and right in bed. The Accident and Incident Report completed by Licensed Practical Nurse Supervisor #1 dated 08/15/2025 documented that at 9:25 PM they were notified by Certified Nurse Aide #2 that Resident #1 was on the floor lying on their right side against the wall. Licensed Practical Nurse Supervisor #1 on the report documented that the fall was unwitnessed, and the resident description section was left blank. The provider and the family were notified. Resident #1 complained of pain to their right shoulder, right knee and x-rays were ordered. The Accident and Incident Report included statements dated 08/15/2025 completed by Certified Nurse Aide #1 and #2. Certified Nurse Aide #1's statement documented they began personal care and told Resident #1 to roll towards the wall so they could wash their backside. Resident #1 slid between the bed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and wall and fell to the floor. Certified Nurse Aide #1 stayed with Resident #1 while Certified Nurse Aide #2 went to get Licensed Practical Nurse Supervisor #1. Certified Nurse Aide #2's statement documented that Certified Nurse Aide #1 told Resident #1 to roll towards the wall. The bed was not locked so when the resident rolled towards the wall the bed slid the opposite way and Resident #1 fell to the floor. Licensed Practical Nurse Supervisor #1 documented the caregivers were educated on always ensuring patient safety, double checking to make sure beds were locked while performing care. The Physicians Orders dated 08/15/2025 documented to obtain an x-ray of the right shoulder and right knee STAT (immediately) for pain related to a fall. A follow up progress note completed by Registered Nurse #3 dated 08/16/2026 documented Resident #1 had some elbow pain and further x-rays were ordered. There was no documented physicians order for an x-ray of the right elbow to be obtained. The Order Summary Report of active orders printed January 21, 2026, did not include an order for a right elbow x-ray dated 08/16/2025, however the diagnostic imaging report dated 08/16/2025 documented there were four (4) views of the right elbow obtained for pain after a fall. The findings documented a normal right elbow. The provider note completed by Physician Assistant #1 dated 08/18/2025 at 3:35 PM documented that Resident #1 was evaluated in follow up after obtaining x-ray results following a fall on 08/15/2025. Physician Assistant #1 documented Resident #1 was receiving hands on care, and the staff did not lock the bed and Resident #1 fell out of bed. The second staff member was not on the other side of the bed to prevent Resident #1 from rolling out. Resident #1 had complained of subsequent right arm pain which was controlled with Tylenol. The provider note completed by the Medical Director dated 08/19/2025 at 3:30 PM documented that staff dropped Resident #1 during hands on care on 08/15/2025 and their right elbow pain persists. On 08/17/2025 the right elbow x-ray was negative. Obtain right radius and ulna (two long bones in the forearm extending from the elbow to the wrist) x-rays if the pain persists. The Physician's Orders dated 08/27/2025 documented an order to obtain an x-ray of the right elbow. The diagnostic imaging report dated 08/27/2025 documented three (3) views of the right elbow were obtained. The findings documented a fracture involving the radial head/neck of the elbow joint (a crack in the top of the forearm bone (radius) at the elbow joint) with soft tissue swelling. The Orthopedic Consult (branch of medicine dealing with conditions affecting the bones) dated 08/29/2025 documented a diagnosis of a right nondisplaced radial head fracture (break in the bone that bone remains in place). Resident #1 was to be non-weight bearing of the right upper extremity and to wear a sling with activity. The sling could be removed for hygiene and removed two (2) to three (3) times per day to work on elbow flexion/extension (hinge point movements) to prevent stiffness. The resident was to avoid pronation (a rotational movement where the forearm turns the palm downward)/supination (the rotational movement where the forearm turns the hand palm up). The Physical Therapy Progress note completed by Physical Therapist #1 on 09/08/2025 at 3:10 PM documented that Resident #1 had actively participated in skilled therapy services with good motivation since 08/13/2025. Barriers to treatment included the resident had a non-weight bearing status to their right lower extremity related to a recent right below the knee amputation. The resident's course of therapy was further complicated by a recent right radial fracture because of rolling out of bed on the nursing unit; causing Resident #1 to maintain non-weight bearing to their right upper extremity; impacting all aspects of functional mobility. During an interview on 01/16/2025 at 10:34 AM, Resident #1 stated that on 08/15/2025 at 9:15 PM Certified Nurse Aide #1 grabbed the draw sheet (a small durable sheet placed crosswise over the bottom bed sheet, spanning from a patient's shoulders to below their buttocks used to assist in repositioning, boosting, or transferring patients) with two (2) hands from under them and forcefully rolled them towards the wall, while Certified Nurse Aide #2 stood at the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	foot end of the bed. Resident #1 stated their right hand hit the wall. The bed was not locked, and it rolled away from the wall causing them to fall from the bed onto the floor hitting their head. Resident #1 stated they had pain in the right shoulder and upper arm. Resident #1 stated they were care planned to have two (2) persons assist them with bed mobility, and they only used one (1). They stated it was determined on 08/27/2025 they had a right elbow fracture. Resident #1 further stated this limited their therapy progress because they could not bear weight on the right upper arm for eight (8) to nine (9) weeks. During a telephone interview on 01/20/2026 at 12:20 PM, Certified Nurse Aide #1 stated they provided care on 08/15/2025 at 9:25 PM. They rolled Resident #1 towards the wall by themselves, placing one hand on Resident #1's shoulder and their other hand on their hip. Resident #1 kept rolling and hit their right shoulder on the wall. The bed was unlocked; it moved away from the wall and Resident #1 fell out of bed to the floor. Certified Nurse Aide #2 was in the room and was standing by the foot board of bed at the time of the fall. Certified Nurse Aide #1 stated they should have waited to roll Resident #1 until Certified Nurse Aide #2 was on the other side of the bed because Resident #1 required two (2) assist for bed mobility. They stated they should have also ensured the bed was locked but they did not. During a telephone interview on 01/20/2026 at 12:31 PM, Physician Assistant #1 stated they evaluated Resident #1 on 08/18/2025. Resident #1 had fallen out of bed during care on 08/15/2025. The two (2) aides did not lock the bed and when the one (1) aide rolled Resident #1, the other aide was not on the other side. They would have expected them to lock the bed and communicate with each other. Resident #1 had complained of right shoulder and ongoing right elbow pain. The right elbow x-ray was negative on 08/16/2025. Subsequently, Resident #1 continued to complain of pain. An additional x-ray of the right elbow showed a fracture on 08/27/2025. Resident #1 had already been at a disadvantage due to a recent below the knee amputation. After the fall and fracture, they were non-weight bearing for their right upper extremity as well. This inhibited Resident #1's therapy progress. The fracture caused excess pain, less independence, physical and emotional harm. During a telephone interview on 01/20/2026 at 4:03 PM, Licensed Practical Nurse #2 stated Certified Nurse Aide #1 and Certified Nurse Aide #2 could have avoided Resident #1's fall had they provided care together and locked the brakes on the bed. During an interview on 01/21/2026 at 11:30 AM, Physical Therapist #1 stated at the time of the fall (08/15/2025) Resident #1 required maximum assistance of two (2) staff members secondary to their size, non-weight bearing to their right lower extremity and they were apprehensive (fearful). Being away from home impacted Resident #1's quality of life and the fractured elbow impacted their rehabilitation capability. The staff should have used two (2) assist for bed mobility. The fractured elbow was significant to Resident #1. Resident #1 was close to reaching their goal in using a slide board (assistive device) for transfers. Right upper extremity strengthening was compromised secondary to the fracture. Transferring with a slide board required both upper extremities, using only the left arm was difficult and therapy was limited. During a telephone interview on 01/21/2026 at 12:18 PM, the Medical Director stated Resident #1 was dropped out of bed by the staff when providing hands on care on 08/15/2025. They ordered a sling and an Orthopedic Consult. They would have expected the staff to follow the care plan. During an interview on 01/21/2026 at 12:20 PM, Registered Nurse #2 Educator stated they would have expected the bed to be secured before providing care. Certified Nurse Aide #1 should have used the appropriate assistance of two (2) for bed mobility. Certified Nurse Aide #1 should have waited for Certified Nurse Aide #2 to be in position before starting care. After the incident on 08/15/2025, an in-service on safe patient handling was completed for the nursing staff. Review of the education dated August of 2025 and staff signature pages revealed the facility educated 30 of 60 nursing staff members between the dates (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of 08/19/2025 -11/13/2025. During a telephone interview on 01/22/2026 at 11:07 AM, Licensed Practical Nurse Supervisor #1 stated on 08/15/2025 Certified Nurse Aide #2 informed them that Resident #1 fell out of bed during care. The bed moved away from the wall at an angle and Resident #1 was on the floor between the bed and the wall. They were informed Resident #1 was instructed to roll towards the wall, the resident pushed off the wall and fell out of the bed. Certified Nurse Aide #1 was the only one providing care at the time of the fall. Licensed Practical Nurse Supervisor #1 stated they immediately notified the provider and called the Director of Nursing and reported the care plan violation. There should have been two (2) persons for bed mobility. The fall out of bed could have been avoided. Resident #1 complained of right elbow pain on and off. On 08/27/2025 a fracture of the right elbow was discovered. During an interview on 01/22/2026 at 11:44 AM, the Director of Rehab Services stated there were two (2) aides in the room. Certified Nurse Aide #1 should not have rolled Resident #1 until Certified Nurse Aide #2 was positioned on the other side of the bed for safety purposes. Anytime they move a resident they should ensure the bed was locked to prevent the resident from moving one way and the bed from moving the other way. The fracture was harmful and impacted Resident #1's therapy due to pain and having non-weight bearing status for the duration. During an interview on 01/22/2026 11:54 AM with the Director of Nursing and the Administrator, the Director of Nursing stated that staff were expected to review the resident's plan of care prior to providing care. They stated if a resident was care planned to have two (2) staff member assist with bed mobility, they would expect staff to follow the care plan and provide safety to prevent accidents. Fractures were considered a significant injury. The Administrator stated Resident #1 was an extensive assist and turned themselves on command. Resident #1 put their hand on the wall, the bed rolled, and Resident #1 fell off the bed. Certified Nurse Aide #1 started to turn Resident #1 and Certified Nurse Aide #2 should have been on the other side to guide Resident #1. The Administrator stated they were not convinced that the fracture was caused by the fall out of bed on 08/15/2025. The fracture was nondisplaced and very subtle. The Administrator stated they believed the fracture came after the incident through performing activities of daily living and continuing therapy. 2. Resident #2 had diagnoses of chronic obstructive pulmonary disease (lung and airway disease that restricts breathing), type 2 diabetes mellitus (chronic metabolic disorder where the body cannot effectively use or produce enough insulin, leading to high blood sugar), and depression. The Minimum Data Set, dated [DATE], documented that Resident #2 was cognitively intact. Resident #2 had lower extremity impairments, required a maximum assist of two (2) with bed mobility to turn right to left, and a maximum assist of one (1) for dressing. The Comprehensive Care Plan dated 07/07/2025 documented Resident #2 required assistance with self-care and mobility and was at risk for falls. Interventions documented the resident required two (2) or more staff members to roll left and right in bed. The Kardex Report dated 05/09/2025 documented Resident #2 was dependent on two (2) or more staff to roll left and right in bed. The Accident and Incident Report completed by Licensed Practical Nurse Supervisor #1 dated 05/01/2025 documented that at 5:30 AM, Resident #2 had a witnessed fall out of bed while they received care which caused an open laceration to back of their head, a laceration to right elbow and laceration to right eyebrow. Resident #2 was transferred to the hospital for further evaluation and treatment. The attending physician and Resident #2's family were notified. The Accident and Incident Report also documented under statements by Certified Nurse Aide #3 that they were getting the resident dressed for the morning and they rolled the resident towards the wall to pull their shirt down in the back and put the sling under them. Resident #2 put their hand on the wall for support, and the bed began to move away from the wall. Certified Nurse Aide #3 documented they tried to hold on to the resident but was unable, and (continued on next page)

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	01/22/2026

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the resident fell between the bed and the wall. The interdisciplinary team met to discuss the resident, staff were educated on locking the beds for safety, and Certified Nurse Aide #3 was to receive corrective action for failure to follow the care plan. The After Visit Summary from the hospital dated 05/01/2025 documented Resident #2 had a fall resulting in a head injury and laceration repair to the forehead. The Progress Note completed by Registered Nurse Unit Manager #4 dated 05/01/2025 at 3:45 PM documented after Resident #2 returned from the emergency room to the facility; the resident began complaining of pain to their facial injuries and their left hand. Upon inspection, it was noted that resident's left middle finger was swollen, bruised and painful with attempted range of motion. The provider was notified, and x-ray was ordered of the residents left hand. The Progress Note completed by Licensed Practical Nurse #4 dated 05/02/2025 at 1:42 AM documented x-ray results received. Left hand with comminuted nondisplaced fracture (a severe break where a bone shatters into multiple fragments but remains in its correct anatomical alignment) of third metacarpal (middle bone). Follow up with provider and an Orthopedic Consult. During an interview on 01/21/2026 at 10:11 AM, Resident #2 stated they were unable to recall if they had a fall causing any injuries. An attempt was made via telephone to contact Certified Nurse Aide #3 on 01/22/2026 at 10:38 AM without success. The line was no longer in service. During a telephone interview on 01/22/2026 at 10:39 AM, Licensed Practical Nurse Supervisor #3 stated this was a tricky situation. They thought it was a break in the care plan but at the time the resident was a one (1) assist for dressing in bed and could not recall what the resident's assist with bed mobility was at the time. Certified Nurse Aide #3 reported to them they rolled the resident over in bed to adjust the resident's clothing and the resident fell off the bed. Resident #2 was sent to the emergency room, for a laceration on their forehead and they also had a broken finger. Licensed Practical Nurse Supervisor #3 stated they could not recall if the bed was locked at the time, but the resident was on the floor between the bed and the wall. During an interview on 01/22/2026 at 11:04 AM, the Registered Nurse #2 Educator stated they were unsure if the bed was locked when the resident fell. They believed the resident required one (1) assist for dressing and two (2) assist for bed mobility. A full in-house in-service on locking the beds and following resident care plans was completed. The facility was unable to provide documented evidence of the education provided regarding locking beds and following resident care plans. During an interview on 01/22/2026 at 11:44 AM, the Director of Rehabilitation Services stated they recalled the resident but not the incident. Resident #2's status prior to the fall was one (1) assist for dressing and two (2) assist for bed mobility. After the fall the resident was changed to have two (2) staff members assist with dressing. The Director of Rehabilitation Services stated all beds should be locked during all care for resident safety. During an interview on 01/22/2026 11:54 AM the Director of Nursing along with the Administrator present, the Director of Nursing stated the incident was a failure to follow the care plan. The resident required one (1) assist in bed for dressing and two (2) assist for bed mobility. Certified Nurse Aide #3 was pulling the resident's shirt down, rolled the resident towards the wall and the resident fell out of bed. The aide thought they were still dressing the resident when they rolled the resident over. The Administrator stated they were unsure if the bed was locked, but it would have prevented the fall. Certified Nurse Aide #3 tried to stop the resident from falling but could not. The Director of Nursing stated they checked all the bed locking devices and in-serviced the staff on locking the beds during care. Beds should be locked during care and staff should be following the residents' plan of care. A fracture was considered a serious injury. The facility was unable to provide evidence that the auditing of the bed locking devices was conducted and evidence that education was provided regarding locking of the beds during care. 10 New York Codes, Rules and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Regulations 415.12(h)(2)