STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335752	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Cheektowaga	225 Bennett Road Cheektowaga, NY 14227

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review completed during a Complaint (2590368) investigation completed on 11/05/2025 the facility did not ensure that residents who had an indwelling Foley catheter (tube inserted into the bladder to drain urine) received the appropriate care and services to manage catheters for one (1) (Resident #3) of three (3) residents reviewed for foley catheters. Specifically, Resident #3 had a history of urinary tract infections and staff did not keep the urine collection bag below the level of Resident #3's bladder while the resident was sitting in their wheel chair, was not wearing a urine collection leg bag (a drainage bag that is attached to the thigh) as care planned, and there was no medical provider orders for the indwelling catheter and/or care of it. Additionally, Resident #3's comprehensive care plan was not updated to accurately reflect their urinary status. The finding is: The policy titled Catheter, Daily Care (Indwelling) dated 11/23/2022 documented residents with indwelling catheters would have daily cleansing of the catheter tubing and perineal area for the purpose of preventing urinary tract infection. The policy documented a urinary drainage bag was always attached in a position below the level of bladder. The policy titled Comprehensive Care plan dated 06/18/2025 documented the nursing home would develop and implement a comprehensive, person-centered care plan for each resident in accordance with Center for Medicare and Medicaid Services regulations. This care plan would address the resident's medical and nursing needs and would be reviewed and revised regularly to ensure optimal care. The policy documented the development of the comprehensive care plan should be a person-centered approach reflecting the resident's preference, goals and values. The policy documented that the care plan should be implemented as soon as it was developed. Review and revise the care plan after each assessment and as needed based on the resident's changing needs and preferences. Resident #3 had diagnoses including severe intellectual disabilities, hydronephrosis (enlargement of the kidney) and retention of urine. The Minimum Data Set (a resident assessment tool), dated 10/24/2025, documented the resident had severe cognitive impairment, was rarely/never understood, rarely/never understands, and had an indwelling catheter. Review of the Comprehensive Care Plan with an initiated date of 10/22/2025 documented Resident #3 had an alteration in bladder/bowel elimination related to chronic foley and left nephrostomy (a thin tube that drains urine from the kidney into a bag). The interventions included that the resident was frequently incontinent of bladder, to provide incontinent care every 2-4 hours, and check and change every 2-4 hours. For an indwelling foley catheter-record output every shift and for a Suprapubic catheter (a tube inserted into the bladder, through the abdomen, to drain urine)-record output every shift. The care plan documented Resident #3 was at risk for infection related to an indwelling urinary catheter. The care plan also documented Resident #3 required an indwelling urinary catheter related to urinary retention, 8/1/25 foley and left nephrostomy tube. Interventions included enhanced barrier precautions in place, provide urinary catheter care daily as needed, urinary leg bag when out of bed and administer medications and treatments per medical doctors/nurse practitioner's orders. The resident did not currently have a left nephrostomy tube or a suprapubic catheter. Review of the Kardex (resident care guide) dated 11/05/2025 documented Resident #3 was frequently incontinent of bladder; had an indwelling foley catheter and to record output every shift. The Kardex documented the resident had a suprapubic catheter and to record output every shift, provide catheter care daily and as needed, and provide urinary leg bag when out of bed. The resident did not have a suprapubic catheter. An undated typed timeline document provided by the Physician Assistant #1 on 11/05/2025 documented that Resident #3 had returned to the facility on [DATE] with an indwelling foley catheter that was placed during the hospital stay, had no nephrostomy tubes as of 09/22/2025, and never had a suprapubic catheter in place. Review of the hospital Discharge summary dated [DATE] at 1:24 PM, documented Resident #3 had a history of urinary retention and a nephrostomy tube secondary to hydronephrosis. It was documented to change the foley catheter every four weeks. Review of the hospital Discharge summary dated [DATE] at 11:56 AM, documented that Resident #3 had just completed a course of antibiotic medication in the past six (6) weeks to treat the resident's right hip septic arthritis along with a concurrent urinary tract infection. Discharge instructions included that indwelling foley catheter in place, will need to be changed every four (4) weeks, outpatient follow-up with urology. Review of the nursing Admission/readmission Form dated 08/01/2025 at 6:01 PM, documented Resident #3 had an indwelling foley catheter and a suprapubic catheter. Review of the nursing Admisison/readmission Form dated 10/20/2025 at 6:08 PM, Registered Nurse #2, Nursing Supervisor