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	04/23/2026

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 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 observations, interviews, and record reviews conducted during survey, the facility failed to ensure that each residents' environment remained as free of accidents as possible and each resident received supervision to prevent accidents for three (3) (Residents #30, #87, and #116) of nine (9) residents reviewed for accident hazards. Specifically, Resident #87 had frequent witnessed and unwitnessed falls from 12/03/2025, through 04/20/2026. The facility failed to assess, implement and evaluate the effectiveness of safety interventions. As a result of the repeated falls, Resident #87 suffered multiple injuries such as bruising, cuts and abrasions. The resident also suffered pain, a left wrist fracture and non-displaced acute fracture of the lateral humeral condyle (elbow); fractures of their left 11th and 12th ribs; an avulsed component (occurs when a ligament or tendon pulls a small piece of bone away from the main bone, caused by sudden, high-tensile force) of the lateral humeral condyle; and a head injury with a change in condition (lethargy and changes in mentation) resulting in an admission to the hospital. This resulted in actual harm to Resident #87. Additionally, Residents #30 and #116 were observed engaged in unsafe smoking practices which included smoking within 30 feet of the facility, extinguishing cigarettes inappropriately and disposing the cigarette butts in garbage cans. Resident #30 had no evidence of a care plan for smoking. The facility policy Prevention and Reporting of Accidents and Incidents for Residents dated 09/07/2023 documented the Accident/Incident Prevention Program includes but was not limited to ongoing resident assessment/evaluation, providing adequate supervision and use of assistive devices to prevent accidents. After the occurrence of an accident/incident, nursing personnel were responsible for the following: the immediate intervention to prevent recurrence was reviewed by the unit manager/designee and revised if necessary. The prevention plan was recorded in the Incident Report, Care Plan, and the Kardex/Profile of Care if applicable. The unit manager/designee was responsible for communicating the plan for nursing staff on all shifts. 1.Resident #87 had diagnoses including progressive supranuclear ophthalmoplegia (a progressive neurodegenerative disease), orthostatic hypotension (orthostasis-low blood pressure that occurs in a standing position), and repeated falls. The Minimum Data Set (a resident assessment tool) dated 01/16/2026 documented the resident had severely impaired cognition, had two (2) or more falls without injury and had one (1) major injury since admission or prior assessment. The Minimum Data Set, dated [DATE] documented the resident had two (2) or more falls and one (1) major injury since admission or prior assessment. Review of the current Comprehensive Care Plan revised 03/26/2026 revealed the resident was at risk for falls related to a history of falls, impulsive, unsteady gait, medication side effects, poor safety awareness, postural instability and progressive supranuclear ophthalmoplegia. Documented safety interventions in place prior to 12/03/2025 included: may sleep in recliner chair located in the unit lounge if restless at night as tolerated; anti-rolls brakes ordered for wheelchair; do not leave alone in wheelchair in room; neuropsychologist consult (psychologist specializing in brain-behavior relationships caused by brain injuries or diseases); offer rest periods in the evening before dinner; occupational therapy to assess ability to use wheelchair brakes; pommel cushion (specialized cushion for pelvic support) (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	chair in use; safety checks every two (2) to three (3) hours on the night shift; assist with walking when restless; staff to assist with getting out of bed between 5:00 AM and 6:00 AM; keep call bell within reach and encourage use; do not leave alone in the bathroom; complete fall risk assessment per policy; include in the fall prevention program; provide a safe environment; educate resident and family regarding safety; nonskid socks in bed, reacher (a tool with a handle and claw used to pick up items without bending or stretching, often used for mobility assistance); wander alert bracelet, and a winged mattress. Additional interventions included scheduled toileting every two (2) hours; check incontinence at night every two (2) hours; ambulation program up to 300 feet daily and may be used as intervention when restless; anti-tippers for wheelchair; corrective lenses; and no water pitcher; encourage activities as tolerated and family visits. Review of the Kardex (a guide used by staff to direct care) dated 04/20/2026 documented the resident may sleep in recliner in lounge chair in the unit lounge if restless at night; do not leave alone in the bathroom; do not leave the wheelchair in residents room; do not leave alone in room unless at bedtime; keep call bell within reach and encourage use; monitor whereabouts due to unsafe wandering/risk of elopement and redirect as needed; non-skid socks when out of bed, non-skid socks when in bed; safety checks every two (2) to three (3) hours on night shift; staff to assist with getting out of bed between 5:00 AM and 6:00 AM; scheduled toileting every two (2) hours; offer a rest period in the evening before dinner, either in bed or recliner chair; safety equipment included a wander alert bracelet and winged mattress. Review of incident reports revealed:Between 12/03/2025 and 12/30/2025, Resident #87 had a total of 18 witnessed and unwitnessed falls with no injuries documented.The accident and incident reports documented the collaborative care plan remained effective and appropriate for patient, did not document any changes and did not address if the plan was effective. The following incident reports revealed the resident sustained injuries related to falls on the following days: On 12/17/2025 at 7:50 AM, fall with minor head injury noted. Referral to physical therapy for a weighted vest (worn for stability/strengthening). On 12/24/2025 at 2:15 PM, they fell, hit their head on the floor, and sustained a cut to their eyebrow and beneath their eye from their glasses requiring first aid. The report documents the plan was followed and did not address revisions or changes in the care plan were made.On 12/26/2025 at 2:25 PM, they were found on the floor and sustained an abrasion to their knee. The resident did not have shoes or non-skid socks in place. The report documented shoes we put on, the resident was picked up and put into their wheelchair. The report did not address if revisions in the care plan were made or whether the current plan was effective.On 12/27/2025 at 6:00 AM, found on floor with minor injury, and a scratch was noted to the back of their neck. The report documented interventions as outlined in the care plan, patient meeting goals regarding behaviors. The report did not address changes to the care plan.On 12/27/2025 at 10:55 AM, self-ambulated and fell into a lamp and furniture, sustained a hematoma (bruise, collection of blood under the skin) to the back and palm of their left hand. No changes to the care plan were made. The report documented the resident was meeting short term goals regarding the reduction of falls. Between 01/02/2026 and 01/28/2026, Resident #87 had a total of seven (7) witnessed an unwitnessed fall with no injuries documented.The report dated 01/05/2026 at 9:15 AM documented a plan change for the resident to have non-skid socks on when out of bed and was implemented on 01/08/2026. There was no documented evidence of additional care plan updates or interventions for the remaining six (6) falls in January 2026 mentioned above.Further review of the incident reports, progress notes and care plan revealed the resident sustained injuries related to falls on following days:On 01/02/2026 at 3:55 PM, found on the floor in front of wheelchair, with noted abrasion to the left side of their forehead. Plan to place a stop sign on the resident's door entrance. Review of the care plan revealed this was implemented on 01/08/2026 and discontinued on 01/15/2026. A progress note dated 01/03/2026 at 9:57 AM, documented the resident's left lower arm, wrist and hand were swollen and they complained of pain. Ibuprofen (pain reliever) was given with no effect. The provider was notified and new orders for a STAT (immediate) x-ray and as needed narcotic analgesic (pain control medication) for five (5) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	days were ordered. At 3:23 PM, the provider and spouse were notified of the left wrist fracture, and the resident was sent to the emergency room that evening.Review of the Radiology Results Reports for the left wrist and left elbow x-rays dated 01/03/2026 revealed a closed (skin intact) acute (new) triquetral (wrist) fracture (break in bone) and a non-displaced (bone cracked) acute fracture of the lateral (outer) humeral condyle, and coronoid process of the ulna (elbow).On 01/24/2026 at 10:10 AM, the resident was found on the floor in the lounge and sustained a scratch to the top of their head. Resident #87 was placed in their wheelchair and given a snack and their call bell and re-educated. The report did not document that changes in the plan were made. Review of the interdisciplinary Progress Notes from 01/01/2026 to 01/31/2026 revealed: On 01/14/2026 at 4:03 PM, resident's quality of life reviewed with interdisciplinary team today, the team feels it would be best to reassess activities of daily living to assure current care plan was appropriate. Resident #87 has no current recommendations at this time. On 01/27/2026 at 12:48 PM, a care plan meeting was held with the resident's spouse present. Nursing reviewed medications and medical status. There was no documentation that Resident #87's frequent falls, or safety interventions were re-evaluated or discussed. Between 02/06/2026 and 02/23/2026, Resident #87 had a total of nine (9) unwitnessed falls with no injuries documented. There was no documented evidence that the resident's care plan was updated.Review of an incident report dated 02/22/2026 at 8:00 AM, revealed the resident attempted to self-transfer and hit the side of the television table. They complained of left side back pain, no visible injuries. A lumbar (lower back) x-ray was ordered. Review of the Radiology Results Reports for the ribs with chest x-ray dated 02/22/2026 revealed acute fractures of the lateral aspect of the 11th and 12th ribs.Review of the interdisciplinary Progress Notes from 02/01/2026 to 02/28/2026 revealed:On 02/22/2026 at 12:36 PM, Licensed Practical Nurse Supervisor #1 reported that the resident had attempted to self-transfer from their wheelchair to recliner and hit the side of the television table. Assessed back redness, provider notified and ordered a lumbar x-ray. At 7:13 PM, acute fractures of the lateral aspect of the 11th and 12th ribs were noted. The on-call provider said to use Tramadol (moderate to severe pain medication) for pain, and if pain was uncontrolled, to call back for further orders.On 02/27/2026 at 5:05 PM, Attending Physician #1 documented the resident had history of dementia with poor safety awareness and recurrent falls. The resident had been having frequent falls secondary to poor safety awareness for some time and fell again over the weekend developed significant issues with pain in the left side and x-rays which diagnostics revealed rib fractures. They remain on fall precautions and will continue to monitor them closely to hopefully prevent further falls in the future.On 02/27/2026 12:44 PM, resident has had increased falls, recent fall with rib fractures, decline in most aspects of activities of daily living, has received therapy services. Decline in BIMS (brief interview for mental status), downgrade in liquids, non-healing wound to left elbow and has not returned to baseline over time. A significant change assessment has been scheduled. Review of an email dated 02/05/2026 at 12:17 PM, provided by the Administrator, Resident #87 was identified in a falls audit, and the Pharmacy Consultant reviewed their medications, and the Medical Director reviewed their chart. There was no documented evidence Resident #87's care plan was updated or that fall or safety interventions were re-evaluated. Between 03/13/2026 and 3/29/2026, Resident #87 had a total of five (5) witnessed and unwitnessed falls with no injuries documented. There was no documented evidence the resident's care plan was updated.Review of an incident report dated 03/05/2026 at 8:30 AM, the resident was witnessed attempting to stand from their wheelchair and immediately fell at nurse's station. They complained of left hip and leg pain. X-rays were ordered, their left elbow wound re-opened, the area was cleansed, and a dressing was applied. Review of the Radiology Results Report for the left elbow x-ray dated 03/05/2026 revealed there was an avulsed component to the previously described fracture of the lateral humeral condyle from the prior study of 01/03/2026. A progress note dated 03/05/2026 at 4:17 PM, documented a meeting that was held regarding the resident's falls. Team and medical director were present. Medication changes were recommended, and the nurse manager will review recommendations with (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the primary doctor. A progress note dated 03/06/2026 at 6:13 PM, Attending Physician #1 documented the resident had poor safety awareness and since the fall resulting in rib fractures, the resident still had issues with falls and developed an open wound on their left elbow and was receiving local wound care. Also complained of left upper extremity pain, and an x-ray showed a subacute lateral condyle fracture that was now avulsed compared to a previous x-ray. The resident's medical marijuana dose was increased from once to twice daily.An incident report dated 03/08/2026 at 12:50 PM, documented the resident stood up from wheelchair, stumbled and fell to the ground hitting the right side of their head. There was an abrasion noted to their scalp. A note on the report dated 03/09/2026 documented staff were to assess the resident for postural hypotension (sudden drop in blood pressure while standing). Review of progress notes revealed no documented evidence that the resident was assessed for postural hypotension, and no care plan changes were made.An incident report dated 03/09/2026 at 7:30 PM, documented the resident was found sitting on the lounge floor. The side table pushed against the wall and lamp knocked over. Resident's left ear was swollen, and ecchymosis (bruising) was noted. The resident was a frequent faller who has exhausted re-education in all areas and may benefit from a one-to-one (1:1) as they were still falling at nursing station and/or lounge. A note on the report dated 03/09/2026 documented the resident may require a care conference to consider one-to-one (1:1) for safety. This was completed by Registered Nurse Supervisor #1. No care plan interventions were documented. An incident report dated 03/17/2026 at 4:45 PM, documented the resident was found on the lounge floor. A very small abrasion noted to their mid back. The resident was unable to state what happened due to their mental orientation but was following direction during assessment. The resident needs a care plan meeting to possibly be a one to one (1:1) for safety concerns as the resident has exhausted all immediate interventions without success. This was completed by Registered Nurse Supervisor #1. No care plan changes were made. An incident report dated 03/18/2026 at 3:38 PM, documented the resident was found on the floor of their bathroom. The resident had skin tears to their right ankle and right knee. A note on the report dated 03/19/2026 documented the resident was discussed at morning meeting and the unit manager was to follow up on the need for pain medications. No care plan changes were made.An incident report dated 03/19/2026 at 1:46 PM, documented the resident was found lying on the floor in the lounge on their right side and they were difficult to arouse at first but then opened their eyes and responded. A progress note dated 03/19/2026 at 2:21 PM, documented the resident was found lying on the floor on their right side and it was difficult to arouse at first. The resident was drowsy, alert and oriented to self at baseline. Recommendation to send to hospital for CT (computed tomography-imaging test) scan of their head and neck. At 10:24 PM, Resident #87 had a reddish/purplish knot on their right temple/forehead. Resident had complained of a headache and had unusual drowsiness. Ice packs were applied, and they were encouraged to stay awake. Neuro checks were initiated. A progress note dated 03/20/2026 at 3:43 AM, documented the resident was admitted to the hospital with a diagnosis of head injury. A progress note by Attending Physician #1 dated 03/24/2026 at 1:15 PM, documented the resident returned to the facility after suffering a fall (03/19/2026) and developed a significant closed head injury, developed issues with lethargy and was sent to the emergency department. Imaging of their head and neck was done and unremarkable although it was found Resident #87 had developed a left hip hematoma (collection of blood under the skin). Medication changes were made for the concern that orthostasis might be contributing to falls. Continue with fall precautions and monitor mental state.Between 04/03/2026 and 4/12/2026, Resident #87 had a total of eight (8) witnessed and unwitnessed falls with no injuries documented. There was no documented evidence the resident's care plan was updated.Review of an incident report dated 04/07/26 at 7:30 AM, documented the resident was found on floor in the lounge; staff had just checked on resident moments prior. Resident denies any new pain but acknowledges chronic back pain. A skin tear was noted to their left knee. Provider saw on rounds and started the resident on Depakote for agitation/mood. Per review of falls, the great majority were related to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	agitation/anxiety/and restlessness. The provider completed a medical review. During an interview on 04/20/2026 at 9:06 AM, Certified Nurse Aide #1 stated they try to have someone sit with the resident to prevent their falls. The staff rotate amongst themselves. They stated that when the resident was alone, they tried to get up or transfer. The resident was fast and fell often. They try to accommodate the resident and have someone keep an eye on them. Certified Nurse Aide #1 stated they had been trying to get one-to-one (1:1) for the resident and the nurses have tried to advocate to the higher ups. Certified Nurse Aide #1 stated they thought Resident #87 liked attention and that was why the one-to-one (1:1) intervention was the only thing that worked (prior to December). Certified Nurse Aide #1 stated administration had never asked their opinion on what to do to prevent the residents' falls, and administration did not know what it was like to try to get their work done with this resident on the unit. The unit staff came up with the idea of switching out someone to sit with the resident because there were not enough staff to have just one (1) person sit with them.During an interview on 04/20/2026 at 9:12 AM, Certified Nurse Aide #2 stated Resident #87 was busy, and they were always up and down. They stated the resident needed companionship and when they were a one-to-one (1:1) a few months ago, they did not fall as much. Certified Nurse Aide #1 stated the resident has had fractures and has gone to the hospital because of their injuries. They stated staff take turns sitting with the resident, they do not sign off that they do this, it was whoever had time at the moment. During an interview on 04/20/2026 at 10:04 AM, Licensed Practical Nurse #2 stated when they work, they take Resident #87 with them when they pass medications. The resident wanted to get up, was bored at times and liked to have someone to talk with. They have told the resident to ask for help, but they still get up on their own. They stated Resident #87 did not like activities, they tried to give them a bag of things to keep them busy, but the resident did not want anything to do with it. The activity staff have sat with the resident but they can only do that for so long. Licensed Practical Nurse #2 stated the resident fell every day, had had injuries and hospital stays, and that their interventions were not working. Licensed Practical Nurse #2 stated the resident had one-to-one (1:1) staff in the past for a short time but they took it away because the resident had a fall while it was in place. When asked what they put in place when the one to one (1:1) was taken away, they stated I don't know, just to keep an eye on (the resident). They take turns watching them and everyone knows the resident falls. During an interview on 04/20/2026 at 10:15 AM, Licensed Practical Nurse Supervisor #1 stated they have tried many interventions. The resident was unsteady when they stand, and they have behaviors. Resident #87 used to have a one-to-one (1:1) for about a week but it stopped. Licensed Practical Nurse Supervisor #1 stated they assumed it was because they needed one (1) specific staff member assigned and they do not have enough certified nurse aides. Licensed Practical Nurse Supervisor #1 stated it was a safety concern with so many falls and injuries. The interventions were not working. The only way to prevent falls was to sit next to them. In the mornings one (1) nurse will do their medication pass while the other one (1) sits with the resident, then they swap places. The resident's family member was very involved and if they have suggestions they will try them. Recently, they put a bell on the wheelchair so the resident could call for assistance, they showed them how to use it, but the resident did not use it. Licensed Practical Nurse Supervisor #1 stated food was a good distraction for a short period, they toilet them and did bladder scans for retention but stated that was not the issue. They have adjusted some medications. When the resident sustained the rib fractures, Licensed Practical Nurse Supervisor #1 had just walked in, went to put their jacket away, heard the other nurse sitting at the desk tell the resident to sit back, and saw them stand and fall into the television stand. Licensed Practical Nurse Supervisor #1 stated everyone knows about this resident's falls, it has been ongoing since they were admitted . Licensed Practical Nurse Supervisor #1 stated they thought they have tried everything and everything has failed and thinks a one-to-one (1:1) staff member was the only option. During a telephone interview on 04/20/2026 at 11:04 AM, Resident #87's spouse stated the resident has had multiple falls. With a lot of falls there were no injuries, but they had rib and wrist fractures in the recent past and have hit their head multiple times. Historically they (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	were always busy doing things and used to be physically able to do it. But now they were no longer physically able. They do not have dementia but were impulsive. They have double vision and cannot ask for help because they cannot get the words out and cannot see well enough to use a communication board. The spouse stated they visit every day, and staff want to do a one-to-one (1:1) with the resident but it is hard to do because of short staffing. The staff at times will sit the resident behind the nurse's station. The resident mostly falls when transferring from the recliner in the lounge to the wheelchair, and if the staff were behind the nurse's desk, they were a little distance away. The resident's family member stated they do not see staff sitting in the lounge with the residents. During a telephone interview on 04/20/2026 at 12:01 PM, Registered Nurse Supervisor #1 stated Resident #87 self-transfers and does not take directions. Nurses keep the resident close by at the nurse's station but not when they were passing medication and the aides were busy. The incident reports they completed documented the resident needed a one-to-one (1:1) but staffing has not been good. They were hoping the unit manager was looking into the one-to-one (1:1) but they resigned. They stated as a supervisor they filled out the incident report, put the resident on report, then there was supposed to be a care plan meeting where the incident report gets signed off by the Director of Nursing and the manager. They do the immediate intervention and contact the provider and family. The problem was the resident had falls multiple times per day, and interventions have been exhausted. They emailed the unit manager with this information. They did not recall if they told the Director of Nursing or Assistant Director of Nursing. They do not think the interventions were being updated. They stated they did not change the care plan because it was the unit managers' responsibility, but they might have been backed up because the resident had such frequent falls. During an interview on 04/20/2026 at 12:45 PM, the interim Director of Nursing stated they try to keep Resident #87 in the common area to be in view of the staff; and when the aides have time to provide one-to-one (1:1) they will do that. The resident's cognition was not always consistent. They have not kept track of the fall interventions; they just look at them when they review the incident reports. Staff have not come to them with concerns about this resident. The nursing supervisor was supposed to do an assessment, help get the residents up, notify the family/medical provider, look for contributing factors/environment and address any immediate needs. The interventions to address falls should be in the care plan and on Kardex but stated they were not sure if they were listed on the incident reports. The unit manager would be responsible for implementing new interventions after a fall. The unit managers report falls in morning report, they discuss interventions with the team, and the unit manager puts interventions in place. The former unit manager had been gone for a few weeks; there was not one (1) person who was covering the unit during their absence. The interim Director of Nursing stated they have not had any interdisciplinary meetings about falls since they have been in the position for the last five (5) weeks. They stated they were not aware of one (1) specific meeting to determine if fall/safety interventions were working, but they were discussed frequently in the morning report meetings. During an interview on 04/20/2026 at 1:17 PM, the Administrator stated they have tried many interventions for Resident #87's falls. They expected new interventions after falls and they tried to review falls within 24 hours after occurrence. Nurses or supervisors were supposed to document what they did, how they addressed the falls, and get staff statements to try to learn from each fall. Resident #87 falls a lot, some interventions were working and some were not. They stated Resident #87 was reviewed daily in morning report because they fall so frequently. During a subsequent interview on 04/21/2026 at 8:12 AM,the Interim Director of Nursing stated they were not aware that there were falls without any interventions. They stated they did not think anyone took minutes during the morning report meeting or documented which cases got discussed. The Interim Director of Nursing stated they had not quantified how many falls Resident #87 has had. The interim Director of Nursing stated the falls were not intentionally causing the resident harm, but any fall could cause harm. They were trying to prevent harm to Resident #87, but the resident can go from compliant to unmanageable quickly. They stated they would have expected a reassessment of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	interventions for falls, like a care plan review every time a new incident report was completed. The Interim Director of Nursing stated they were supposed to ensure the unit managers were updating the care plan interventions. The resident sat in the lounge a lot, there was not a call bell in the lounge, and they were not sure if a weighted vest was tried. During a subsequent interview on 04/21/2026 at 8:29 AM, the Administrator stated they were not aware the resident's care plan interventions were not updated. They had their consultant pharmacist look at the resident's medications in February and their medical director looked at the resident. They stated they did not think anything was wrong with their interventions. The Administrator stated they expected the unit managers to update the care plan, and that no unit managers ever came to them with problems. Falls can be potentially harmful, that is why they put interventions in place. If an intervention was not done, a resident could get hurt. When they run out of interventions they would have to do other things, like sit with the resident 24/7 but did not think this would help because the resident had a fall with a one-to-one (1:1) staff member in place.During an interview on 04/21/2026 at 9:22 AM, Attending Physician #1 stated Resident #87 fell all the time. They tried to get up on their own and staff have them in the common area but sometimes they snuck into their room. Staff have tried toileting them regularly, they were adjusting medications, and nothing had really helped. The resident had rib fractures and now a mildly avulsed lateral condyle fracture. They have tried adjusting medications and they see the resident weekly for falls. The nurses were exasperated by it. It is a difficult case, and it was hard to say if the falls have caused them harm. They did not know what else to do to prevent them without tying (Resident #87) down. The falls were so frequent that a new intervention was not expected after each fall, but maybe every week or so they should try to figure out what to do to help decrease the number of falls. During an interview on 04/21/2026 at 9:54 AM, Occupational Therapist #1 stated they worked with the resident after they had a fall and injured their wrist, they required a splint. They were not sure if the therapy department saw them after each fall. They stated the resident needed a one to one (1:1) and they made that recommendation in December to see if there was an option through veterans affairs. Resident #87's falls were a result of their behavior; they were quick when they wanted to be. They tried a scoot chair (designed to reduce falls in nursing home residents who propel themselves with their feet) for the resident back in December for several days, but the resident did not tolerate it and their behavior got worse. They were not sure about a weighted vest intervention but maybe the Director of Rehab knew more about that. Occupation Therapist #1 stated the falls were causing the resident harm, they have not been involved in any meetings about this resident.During an interview on 04/21/2026 at 10:20 AM, the Director of Rehabilitation stated in morning report they talk about falls and try to brainstorm as a team. They had a meeting with the Medical Director regarding Resident #87 but did not remember the date of the meeting. Aside from morning meetings, nothing else occurred, unless it was without their presence. They knew Occupational Therapist #1 recommended a one to one (1:1) in December and they were able to provide it if they have adequate staffing. They thought Resident #87 could benefit from a one-to-one (1:1). They were not aware of a weighted vest intervention and did not know if the facility had access to one. It could potentially be a good idea if Resident #87 was comfortable with it. During a telephone interview on 04/21/2026 at 10:43 AM, the Medical Director stated they have been at the facility since January and did not manage Resident #87 clinically, but they had seen them once in February and were aware of their falls. They talked about adjusting their medications and Sinemet (medication to treat Parkinson's disease/symptoms) could potentially be overstimulating, so they had decreased that dose. Resident #87 had poor safety awareness. They probably have core balancing issues with weakness and instability related to their progressive neurological condition. They have had a couple rib fractures and an elbow fracture that were managed supportively. The resident was pleasant but cognitive function was not there to make them aware of their current medical diagnosis. Falls have the potential to cause them harm as they have had injuries, but the injuries did not limit the resident. The Medical Director stated they needed interdisciplinary team consensus to determine whether new fall interventions would be appropriate

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	335752	A. Building B. Wing	04/23/2026

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, interviews, and record reviews conducted during the survey, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for four (4) (Unit One, Unit Two, Unit Three, and Unit Four) of four (4) resident units. Specifically, Resident #155's bathroom was damaged and dirty; bathing suites exhibited damaged floor and wall tiles, a damaged corner wall, damaged and loose grab bars, chipped paint, soiled shower curtains, dead flies, clogged drains, and a florescent light outage; and resident-use corridors had discolored and malodorous carpeting throughout the entire facility.The findings included: The facility policy titled Kitchen, Dining and Dietary Equipment Routine Cleaning Policy, last revised 04/26/2019, documented the dietary work areas would be kept clean and in order by designated department staff and daily housekeeping staff duties included: cleaning of floors after a meal in the dining areas and in other eating areas of the building. The facility policy titled Maintenance Repairs, last revised, 07/22/2025, documented the Maintenance Department Management would be responsible for building equipment repairs. The Manager/Supervisor decided whether environmental services staff or an outside agency made needed repairs. The Maintenance Management assessed the extent of repairs needed, identified in work orders by the facility staff. In all instances of inside or outside source repair, requests were documented in writing on the facility's TELS (a comprehensive building management platform used to manage maintenance, repairs, compliance, and asset tracking) system. The facility policy titled Cleaning Schedule - Housekeeping, last revised 02/09/2026, documented the Supervisor of Housekeeping/Laundry would ensure that the facility would be maintained in a safe, attractive, sanitary, and clean state for residents, staff, and visitors. A Master Cleaning Frequency Schedule for the facility would be developed in cooperation with the Administrator and Chief Operating Officer/designee. The Supervisor of Housekeeping/Laundry would report on the status of meeting cleaning frequency goals as part of the monthly report to the Administrator. The following was included, but not limited to, in the Master Cleaning Schedule Guide: - Resident Rooms/Bathrooms: Daily - Vacuum carpets and sweep/mop/buff tile floors. Bimonthly - Shampoo carpets. Annually - Clean light fixtures, cubicle curtains, drapes, and ceilings.- Nursing Station/Medication Room/Treatment Room/Nourishment/Kitchenette: Daily - sweep/mop/buff tile floors. Weekly - Shampoo carpets and spray buff tile floor. Biannually - Strip and refinish tile floors.- Showers/Tub Rooms: Daily - Disinfect and wash walls, tubs, and shower area, mop tile floors. Biannually - Clean shower curtain. Annually - Clean light fixtures and ceilings.- Hallways: Daily - Vacuum carpets and sweep/mop/buff tile floors. Weekly - Shampoo carpets.- Public Bathrooms (Visitor and Resident): Daily - Sweep/mop/buff tile floors. Biannually - Strip and refinish tile floors. Annually - Clean light fixtures and ceilings.- Resident and Visitor Lounges: Daily - Vacuum carpets, sweep/mop/buff tile floors. Weekly - Spray/buff tile floors. Biannually - Shampoo carpets, and strip and refinish tile floors.Lobby and Vestibule: Daily - Mop vestibule floor and vacuum carpet. Weekly - Bonnet buff carpets. Biannually - Shampoo carpet. Annually - Scrub vestibule floor.- Ceilings and Wall Vents Throughout Building: Monthly - Dust sprinkler heads. Bimonthly - Dust wall or ceiling vents. Annually (or as needed) - Clean ceiling tile strips. The job description of a Housekeeper documented that they assisted with ensuring the health and well-being of residents by providing housekeeping support. They were responsible for maintaining the cleanliness of all facility areas, including but not limited to, resident rooms, common areas andoffices. Essential job functions included but were not limited to: Kept facility environment in a sanitary, odor-free, attractive and orderly condition; maintained cleanliness of general areas and assigned rooms of residents; vacuumed and mopped tile floors using proper procedures and appropriate equipment and solution; vacuumed, wet vacuumed, and extracted carpeted flooring; cleaned bathrooms by disinfecting, scouring, and polishing fixtures; and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reported any needed repairs in building or furnishings to Administrator and/or Director of Maintenance. The job description of a Certified Nursing Assistant documented that they assisted with ensuring the health and well-being of residents by providing direct nursing and personal care support. The job description included but not limited to timely reported facility equipment that needed repair and unsafe conditions in room or unit area. The job description of a Nursing Unit Manager documented requirements which included current registration to practice as a Registered Professional Nurse or Licensed Practical Nurse. The job summary documented that the Nursing Unit Manager responsibilities included but were not limited to: Conducted Daily Rounds to note the status of resident care and the environment; ensured the unit and environment was maintained in good order for the well-being of staff and residents; promoted safety awareness The job description of a Maintenance Assistant documented that they assisted with ensuring the health and well-being of residents and staff by providing maintenance support. They were responsible for ensuring overall building safety by being responsible for repairs to the buildings and furnishings. Essential job functions included but were not limited to: Assisted with and performed assigned duties related to electricity, plumbing, painting, carpentry; mechanics (including equipment and mechanical systems); heating, cooling and water systems (except those services performed under service contracts with outside contractors). The job description of the Director of Facilities Management-Campus documented that they were assigned to a campus or multi-site location and responsible for complete operations, property management, and oversight for Environmental Services and Maintenance departments. They managed life safety compliance, staff, day-to-day operations, and budget for each site as well as regular maintenance checks, repairs, coordinating vendors/contractors, record-keeping and supplies and equipment. The Director of Facilities Management-Campus followed established safety rules, policies and procedures of the departments. Essential job functions included but were not limited to: Responsible for fire safety, maintenance, and environmental services support to assigned campus/locations; responsible for Preventive Maintenance Plans; supervised and responsible for Maintenance and Environmental staff; oriented, instructed, trained, and supervised departmental staff; assigned duties and evaluated work performance; and maintained environmental compliance for all regulatory agencies. 1. During an observation and interview on 04/15/2026 at 4:16 PM of Resident #155's bathroom, there was an area of damaged drywall that measured approximately 6-inches in diameter to the right side of the mirror above the shelf. The bathroom floor around the room perimeter, around the toilet and the corners were grey and dirty. The dark brown baseboard had whitish discolored areas, and the white caulking around the toilet base was cracking. Resident #155 stated the damaged drywall looked filthy and was not very sanitary. Resident #155 stated they had complained about it at some point, but it never got fixed. During an observation and interview on 04/22/2026 at 1:45 PM, the Environmental Services Manager observed Resident #155's bathroom and stated they needed to clean around the baseboards and toilet more, the edges looked like dirt or wax buildup were pushed into the edges. Additionally, the Environmental Services Manager stated the baseboards needed to be replaced as they were as old as the building. Furthermore, the Environmental Services Manager stated the drywall was peeled and it looked like the soap dispenser pulled away or fell off and the wall needed to be patched. Finally, the Environmental Services Manager stated nursing staff, housekeeping staff, or anyone that saw it should have reported the issues to maintenance. During an observation and interview on 04/23/2026 at 12:19 PM, the Director of Plant Operations observed Resident #155's bathroom wall and stated they were not aware of the damaged drywall, and staff should have notified them so it could be fixed. The Director of Plant Operations stated it was not homelike, and if this was in their house, they would have fixed it. Resident #155 was in their room during the observation and stated, are you going to fix my wall in there?. 2. Review of work orders, dated January 2026 to April 2026, revealed no documented evidence that work orders were placed for any shower rooms. During observations on 04/22/2026:- at 12:29 PM, the Unit Two bathing suite across from resident room [ROOM NUMBER] and #142 revealed a dust (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	laden wall and vent above the entry door; one (1) of two (2) shower curtains were soiled on the lower corners with brown smudges; the lift seat to the tub was cracked at the center seam; the exterior-side of the restroom door had an area of chipped paint approximately 4-inches in diameter and the interior-side of the restroom door had minor chipped paint areas on the surface; and both the exterior and interior sides of the restroom door had heavy scrape markings along the base.- at 12:40 PM, the Unit One bathing suite across from resident room [ROOM NUMBER] and #127 revealed the shower drain was clogged with hair and a plastic wrapper; one (1) of two (2) shower curtain liners were frayed along the base; approximately one (1) dozen dead flies were in the corner of the closet; the exterior-side of the restroom door had an area of chipped paint approximately 12-inches in diameter; both the exterior and interior sides of the restroom door had heavy scrape markings along the base; and the restroom ceiling tile was damaged with an approximate 1-inch by 6-inch slit above the toilet. - at 12:59 PM, the Unit Four bathing suite across from resident room [ROOM NUMBER] and #242 revealed the shower floor was missing an approximate 4-inch by 5-inch tile section.- at 1:02 PM, the Unit Three bathing suite across from resident room [ROOM NUMBER] and #227 revealed the florescent ceiling light by the entry door was not working, causing the shower room to be completely dark; the floor in the shower room was wet and steam was present; the restroom grab bar parallel to the toilet bowl was loose and shifted side-by-side within an approximate half-inch area; several chipped paint areas, each approximately 1-inch in diameter, were scattered on the exterior of the restroom door; and the lower portion of the shower curtain was darkly soiled. During an interview on 04/22/2026 at 1:05 PM, Certified Nurse Aide #17, the Certified Nurse Aide Mentor, stated the ceiling light in the Unit Three bathing suite across from resident room [ROOM NUMBER] and #227 had been out for one (1) to two (2) weeks. Licensed Practical Nurse #4, the unit manager, stated it was the first time they heard about the light outage in that shower room, the facility used TELS (a comprehensive building management platform used to manage maintenance, repairs, compliance, and asset tracking), and the issue could have been reported through that system. Licensed Practical Nurse #4 further stated that certified nurse aides provided showers for residents, and the expectation was they would inform them, the unit manager, if a light was out. During an interview on 04/22/2026 at 3:12 PM, Resident #155 stated the shower rooms were not homelike, there was hair in the drains, and the call light was not accessible. During an observation and interview on 04/22/2026 at 3:14 PM, Certified Nurse Aide #7 stated the shower room on Unit Four had been missing tiles and the grout had been black for as long as they had worked there, which was three (3) years. Certified Nurse Aide #7 further stated the process was to put a work order into the system and have maintenance come and fix the tiles, but they were unaware if any work order request had been submitted. Additionally, Certified Nurse Aide #7 stated housekeeping was responsible for deep cleaning the shower stalls. During an interview on 04/22/2026 at 3:42 PM, a family member of Resident #27 stated the facility was filthy and dirty. During observations and an interview on 04/22/2026 at 3:55 PM in the Unit Three bathing suite across from resident room [ROOM NUMBER] and #227, Licensed Practical Nurse Unit Manager #4 stated the ceiling light was not working, the shower room was dark, the restroom grab bar parallel to the toilet was loose, there were several spots of chipped paint on the restroom door, and the shower curtain was soiled. During observations and interviews on 04/23/2026 at 10:02 AM, Licensed Practical Nurse Supervisor #1, stated the Unit Two bathing suite across from resident room [ROOM NUMBER] and #142 was not used by unit staff to help bathe residents; rather, the bathing suite across from resident room [ROOM NUMBER] was used. Observations of the bathing suite across from resident room [ROOM NUMBER] included but were not limited to the following: deteriorated caulk in the corner of the shower room, which spanned from floor to ceiling; two (2) approximately 0.5-inch by 0.5-inch areas of missing shower tile; soiled and deteriorated tile grout throughout the shower floor; several small penetrations and adhesive debris on the shower wall; the grab bar in the restroom had an approximate 6-inch diameter penetration in the wall causing the grab bar to become unsteady; several restroom baseboard tiles had soiled, missing, or deteriorated caulk; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and the base of the restroom doorframe was damaged and deteriorated. During an interview at the time of the observations, Licensed Practical Nurse #1 stated they did not care about the condition of the bathing suite because they were a nurse, it was not their job to bathe the residents, and that it was the job of the certified nurse aides to bathe the residents. Licensed Practical Nurse #1 further stated certified nurse aides were also not responsible for reporting issues in the bathing suites other than the water temperature and pressure. Certified nurse aides and licensed practical nurses would not report missing tile, soiled grout, or loose grab bars because those issues were housekeeping concerns and therefore would not be reported in TELS (a comprehensive building management platform used to manage maintenance, repairs, compliance, and asset tracking) by nursing staff. During an observation and interview on 04/23/2026 at 10:34 AM, Registered Nurse #5 Unit Manager, stated the shower room on Unit Four should not have matted hair in the drain, dark brown/black debris in the grout, or missing tiles. Registered Nurse #5 further stated the housekeeper was responsible for deep cleaning the shower rooms, and anyone who gave a shower could report missing tiles. Additionally, Registered Nurse #5 stated it was a safety and infection control issue, and the issues were not homelike. During an observation and interview on 04/23/2026 at 10:36 AM, Housekeeper #1 stated they had never personally deep-cleaned the shower room on Unit Four or reported to maintenance the missing tiles. Housekeeper #1 further stated deep cleaning the shower was important for cleanliness and having a dirty and damaged shower was not homelike. During an interview on 04/23/2026 at 10:44 AM, Housekeeper #4 stated they were responsible for cleaning toilets, sinks, restroom and shower room floors. Housekeeper #4 further stated they floated throughout the facility and did not notice issues in the bathing suites; however, if they did, they would report any issues to the Maintenance department. During an observation and interview on 04/23/2026 at 10:46 AM, Housekeeper #2 stated the shower room on Unit Three could be scrubbed and cleaned better, and it was not homelike. During an observation and interview on 04/23/2026 at 11:12 AM, Housekeeper #3 stated the housekeeper was responsible for deep cleaning the shower rooms. Housekeeper #3 further stated the shower room in Unit One had hair matted in the drains and the grout was discolored, which was not homelike. During an observation and interview on 04/23/2026 at 11:40 AM, Certified Nurse Aide #23 and Resident #1 exited from the Unit Four bathing suite across from resident room [ROOM NUMBER] and 242. Further observation revealed the bathing suite's shower floor was missing an approximate 4-inch by 5-inch tile section and hair clogged the shower drain. Certified Nurse Aide #23 reentered the bathing suite and stated they had just finished helping Resident #1 with a shower and did not notice the missing tile and the clogged drain. During an observation and interview on 04/23/2026 at 12:15 PM, the Director of Plant Operations stated that other than one (1) damaged ceiling tile in January 2026, there were no TELS (a comprehensive building management platform used to manage maintenance, repairs, compliance, and asset tracking) requests for bathing suites. During observations and interviews on 04/23/2026 at 12:25 PM in the Unit Two bathing suite across from resident room [ROOM NUMBER], the Director of Plant Operations stated the inside corner piece of the shower room needed to be replaced, the caulk was damaged, and the ceiling grid work expanded. The Director of Plant Operations further stated all staff, including nursing and housekeeping, had access to TELS (a comprehensive building management platform used to manage maintenance, repairs, compliance, and asset tracking), they were not made aware of the damaged wall surrounding the grab bar in the restroom, and if maintenance had known about those issues they would have been corrected. During an interview on 04/23/2026 at 1:22 PM, the Administrator stated every staff member had access to the TELS (a comprehensive building management platform used to manage maintenance, repairs, compliance, and asset tracking) system, and anything maintenance-related was reported in this system. The Administrator further stated staff could even take a picture of the issue and complete the report over their phone, which would then be categorized by priority. Additionally, the Administrator stated they would expect certified nurse aides and housekeeping staff to report issues within bathing suites, like a light outage, and it was important (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to report those issues for safety reasons. 3. During an observation on 04/15/2026 at 8:55 AM, the Second-Floor hallway carpet by the elevator had a multitude of large discolorations and a malleable texture when walking on it. Further observations revealed the Unit Three carpet on North Hallway, near resident room [ROOM NUMBER], had a large dark circular discoloration approximately 2-inches in diameter. Additionally, observations of carpet on [NAME] Hallway revealed a large dark circular discoloration approximately 2-inches in diameter near resident room [ROOM NUMBER], and another large dark circular discoloration approximately 1-inch in diameter near resident room [ROOM NUMBER]. Furthermore, observations of the Second-Floor hallway near the dining room revealed two (2) dark discolorations approximately 1-inch by 6-inches and 2-inches in diameter, respectively. During a telephone interview on 04/16/2026 at 10:11 AM, Resident #70's responsible party stated the carpets at the facility were filthy and it smelled nasty, like urine when you walked onto the units. During an interview on 04/20/2026 at 3:54 PM, Resident #77's responsible party stated all the floors could be cleaner in the facility, and if their floors at home looked like the facility's floors, they would make sure they were cleaned and not stained like the facility's floors. During an observation and interview on 04/22/2026 at 1:40 PM, the Environmental Services Manager said the rug was [AGE] years old and needed to be replaced. The Environmental Services Manager further stated replacement of the carpet had been presented to the owners, but they had not gotten any estimates or anything like that yet. The Environmental Services Manager observed carpeting the hallway of Unit Two and Unit Four and stated it was worn out and discolored. Furthermore, the Environmental Services Manager stated the spots were mostly food tray spills and if the dining rooms were used as they should be, then the food would not be on the units all the time. Observation of corridors on 04/23/2026, included but were not limited to the following:- at 10:33 AM, an approximate 6-inch diameter carpet discoloration by resident room [ROOM NUMBER].- at 10:34 AM, two (2) carpet discolorations by Unit Two Soiled Utility Room; one (1) approximately 6-inches in diameter and one (1) approximately 18-inches in diameter, respectively.- at 10:37 AM, several streaks of carpet discoloration by resident room [ROOM NUMBER]; each approximately 2-inches by 18-inches.- at 10:39 AM, an approximate 6-inch by 24-inch area of carpet discoloration by resident room [ROOM NUMBER]- at 10:43 AM, an approximate 10-inch diameter carpet discoloration by resident room [ROOM NUMBER].- at 10:57 AM, an approximate 36-inch diameter carpet discoloration by the Unit One Soiled Utility Room.- at 11:02 AM, an approximate 36-inch by 48-inch carpet discoloration by resident room [ROOM NUMBER].- at 11:37 AM, an approximate 4-inch by 6-inch area of thick food debris on the carpet by resident room [ROOM NUMBER].- at 11:38 AM, an approximate 12-inch diameter carpet discoloration by the Unit Three Soiled Utility Room.- at 11:44 AM, two (2) areas of carpet discolorations between resident room [ROOM NUMBER] and #255; each approximately 12-inches in diameter. During an interview on 04/23/2026 at 10:30 AM, Occupational Therapist #1 stated there was an overall urine smell throughout the facility, and they had concerns of resident restroom cleanliness, curtain cleanliness, broken resident room window blinds, and lowlighting throughout the facility. During an observation and interview on 04/23/2026 at 10:31 AM, Resident #69 was wheeling down the corridor between Unit Two and Therapy, and there were multiple large dark brown circular discolorations on the carpets throughout the corridor. Resident #69 stated the spots on the carpet probably had a lot of bacteria and it bothered them. During an interview on 04/23/2026 at 10:42 AM, Resident #10 stated the carpets should be replaced because they were all faded, and staff were always having to wash them. During an interview on 04/23/2026 at 10:44 AM, Housekeeper #4 stated the carpets needed to be replaced because they were old and smelly. Housekeeper #4 further stated they floated throughout the facility, noticed carpets were stained on all resident units, and food was often spilled on the carpets. During an interview on 04/23/2026 at 10:55 AM, Housekeeper #3 stated certified nurse aides dropped residents' meals onto the hallway carpets. Housekeeper #3 further stated they used a cleaning solution with urine remover to combat the urine smell. Additionally, Housekeeper #3 stated they reported loose toilet seats to the maintenance department in (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the past, and if there were any maintenance-related issues they could also report them to their supervisor. During an interview on 04/23/2026 at 12:00 PM, a family member of Resident #156 stated the carpets were a problem and the stains were prevalent. During an interview on 04/23/2026 at 12:50 PM, the Director of Plant Operations stated the carpet squares used throughout the facility's hallways were obsolete, the manufacturer did not make them anymore, and they could not be replaced. During an interview on 04/23/2026 at 1:22 PM, the Administrator stated the building was very old and they had a floor tech that buffed the floor about every other day or when needed. The Administrator further stated the carpets were something the facility was working on, but resident care was more important. Additionally, the Administrator stated they needed to ensure the facility was staffed properly because they had more complaints with the staff than the carpets. Furthermore, the Administrator stated the families on the subacute units had issues with the carpets, complaining that they were dingy. The Administrator continued to state the carpets were beyond their control and they put carpet concerns in their capital budget, but the decision to ultimately replace the carpet was determined by their corporation. The Administrator also stated they had a meeting with corporate in October 2025 and they were aware of the carpet issue. Finally, the Administrator stated they were aware of the smells and stains, and it did not create a homelike environment for the residents. 10 New York Codes, Rules, and Regulations (NYCRR) 415.5(h)(1)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record review conducted during the survey, facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to have sufficient nursing staff to provide nursing care to all residents in accordance with the facility assessment and to meet the needs of each resident. Residents #1, 3, 10, 30, 52, 69, 70, 90, 102, 117, 122, 151, 155, 156, and 167 were involved.The findings include:Refer to F 561 Self Determination, Scope and Severity D Refer to F 677 Activities of Daily Care for Dependent Residents, Scope and Severity DRefer to F 689 Free of Accident Hazards/Supervision Scope and Severity GThe policy titled Minimum Nursing Staffing Requirements dated 08/21/2025 documented staffing levels will be determined by the Administrator in cooperation with the Regional Director of Operations, Chief Operating Officer, Chief Nursing Officer, and the Governing Body. Staffing levels are based on, but not limited to, the facility assessment that outlines the residents' population and acuity, facility layout, census projections and staff skill levels and competencies consistent with state and federal requirements. The Nursing Master Staffing Plan will be reviewed annually or when necessary.Review of the Facility assessment dated [DATE] documented the facility had 172 licensed beds and their average daily census was 150. Staffing needs were based on total resident population, resident acuity and facility physical plan layout. The staffing plan was reviewed at a minimum of annually or as resident acuity changes necessitated revision. The Direct Care Nursing Staffing Plan attached to the Facility Assessment was dated 07/01/2025. The Minimum Staffing Plan for certified nurse aides were five (5) on each unit (20 total) for day shift, four (4) on each unit (16 total) for evening shift and two (2) on each unit (8 total) for night shift with an anticipated average census of 162.During an interview on 04/22/2026 at 8:22 AM, the Administrator stated per their Facility Assessment staffing numbers are four (4) certified nurse aides per unit on day and evening shift, and two (2) per unit on night shift, that was what they like to see. However, their minimum staffing numbers were three (3) certified nurse aides per unit (12 total) on day and evening shifts and one (1) per unit (4 total) on night shifts. Their minimums could change based on the census. If there were two (2) certified nurse aides on an evening shift, they would float someone from another unit or ask therapy to come in and work as an aide. They were fully staffed for nurses, so they have nurses who will drop down and work as an aide. They terminated their scheduler in January, and a new one started two days ago. The Administrator stated two (2) aides (on a unit) were not ok to work with. Day shift and part of evening shift were fully staffed. A lot of staff likes to leave at 7:00 PM, and they try to get night shift to come in early and puzzle it together.Review of the Unit Assignment sheets (staffing sheets) revealed the facility did not meet their minimum number of certified nurse aides on the following shifts:-On 02/21/2026 evening shift there were 11 certified nurse aides until 6:00 PM, after 6:00 PM there were nine (9) certified nurse aides: (down 1 until 6:00 PM and down 3 after 6:00 PM)-On 02/22/2026 day shift there were ten (10) certified nurse aides until 11:00 AM and there are multiple notes that staff were late or went home. There were no notes that any nurses worked as certified nurse aides; (down 2.5)-On 02/22/2026 evening shift there were six (6) certified nurse aides, plus 1 (one) nurse worked as an aide, and another nurse worked as an aide until 7:00 PM; (down 4.5).-On 03/22/2026 evening shift there were nine (9) certified nurse aides (including one (1) nurse that worked as an aide); (down 3).These numbers were based on the Administrator's stated minimum staffing numbers during the interview on 04/22/2026 at 8:22 AM.Review of the Resident Council minutes from February 2026 to April 2026 revealed the following:02/09/2026 - short staffing, no nurses/no structured schedules; staff were not answering call bells; aides were reporting to residents they were not on my list or I will tell your aide; staff will come and turn the light off but not (continued on next page)

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	335752	A. Building B. Wing	04/23/2026

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	attend to the resident; staff are on their phones while providing care.03/09/2026 - call lights were not being answered, aides were sitting at nurses' station excessively, aides enter resident room to answer call light, turn it off and never return.04/13/2026 - staff and aides were leaving before their shift was over; call lights not being answered or call lights being ignored; aides not assisting with hygiene.Observations and interviews with residents, resident representatives, and staff revealed:During an interview on 04/15/2026 at 9:23 AM, Resident #122 stated day shift staffing was ok, but around 2:00 PM it starts slowing down because they only have three (3) aides. When they needed their brief changed, they put on their call light and waited 45 minutes for them to answer their light. They timed them with their clock. During an interview on 04/15/2026 at 9:45 AM, Resident #10 stated there was not enough staff here. They were independent and did not need a lot done for them, but things were delayed like meals were late. If they do ring their call bell for something, they wait a long time, about 30 minutes. Weekends were the worst and some mornings only one (1) aide shows up.During an interview on 04/15/2026 at 10:10 AM, Resident #90 stated when they ring the call light it took quite a while for someone to answer it. They stated the facility did not have enough help; they preferred to be out of bed by 9:00 AM so they could go to therapy. Resident #90 stated the therapist came to get them for therapy at 9:00 AM, but they were not out of bed yet, so they put their call light on and were still waiting for staff to assist them. Resident #90 stated the weekends were exceptionally bad and they did not get their scheduled showers on Sundays due to there not being enough staff.During an interview on 04/15/2026 at 10:12 AM, Resident #3 stated the facility was short on help. They come when they can, but sometimes they wait 20 minutes to half an hour when they use their call bell. Somebody was supposed to take them to bathroom when they had to go but has had to wait and if they did not come right away, they have accidents, and it made them feel bad.During an interview on 04/15/2026 at 10:19 AM, Resident #30 stated they have been at the facility for four (4) years. Everything started out okay, but the facility has gone downhill since then and nothing was consistent. They stated, for example, they liked to get up and out of bed in the morning and there were times when they would be left in bed until after 11:00 AM. Resident #30 stated they asked staff why they left them in bed so long and they say it was because they did not have enough staff.During an interview on 04/15/2026 at 10:19 AM, Resident #167 stated they waited 45 minutes to one (1) hour on Saturday night for staff to answer their call light after they threw up on themself. They stated there had been multiple times they rang their call light because they were incontinent and waited between 30 minutes to 45 minutes for their call light to be answered. There had also been times they rang their call light, staff answered the light and turned it off, did not provide any help and never come back.During an interview on 04/15/2026 at 10:34 AM, Resident #164 stated staffing was horrible and they were not attentive to the people. They stated they would hit their call light and wait between 30 to 45 minutes on a regular basis and were stuck on the toilet for over 30 minutes recently which caused their anxiety to get worse.During an interview on 04/15/2026 at 10:41 AM, Resident #151 stated it could take 30 minutes to hours for staff to answer the call bell. This past Sunday there was no nurse, and they did not have one aide come in and check or change them from 7:00 PM to 7:00 AM when the day shift came in. They were incontinent with urine and had to lay there soiled for hours.During an interview on 04/15/2026 at 11:06 AM, Resident #52 stated when they ring their call bell, they waited about a half hour for someone to respond, or they tell the resident when the next shift comes in, they'll change their brief.During an interview on 04/15/2026 at 3:44 PM, Resident #155 stated there was never enough staff. Call light response depended on the aides working. A lot of times at 8:00 PM they all leave, and nobody was there until the next shift. Sometimes they do not come at all, and they had to wait for the next shift. They have reported this to the social worker, and they were told they were trying to take care of it. During an interview on 04/16/2026 at 8:49 AM, Resident #117 stated getting up before breakfast had been difficult at times due to lack of staff. Staff assignments changed frequently and that disrupted the normal process.During a telephone interview on 04/16/2026 at 10:11 AM, Resident #70s responsible party stated there were multiple times they (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	came in to visit their family member on the weekends and were told Resident #70 could not get their scheduled shower on Sundays due to their being only two (2) certified nurse aides.During an interview on 04/16/2026 at 11:21 AM, Resident #1 stated normally on the 2:00 PM-10:00 PM shift you have to wait hours for them to answer call lights. During an interview on 04/16/2026 at 12:12 PM, Resident #69 stated they had to wait a long time when they put their call bell on to be changed. It happened every other day. Sometimes staff come in and say they'll be back, but they don't come back and nothing gets done. During an interview on 04/17/2026 at 9:31 AM, Certified Nurse Aide #3 stated when there were only three (3) certified nurse aides on the unit, the assignments were very heavy. They stated when there were three (3) certified nurse aides or less on the unit, they did not have the time to get residents up at their preferred times and the dining rooms were not open then because there were not enough staff. Certified Nurse Aide #3 stated one of the biggest issues the facility had was staffing.During an interview on 04/20/2026 at 6:50 AM, Licensed Practical Nurse #5 stated their shift ended at 7:00 AM and the following staff were scheduled to work on Unit 4 that morning: two (2) certified nurse aides from 6:00 AM to 2:00 PM, two (2) Licensed Practical Nurses from 7:00 AM to 3:00 PM, and one (1) additional certified nurse aide from 7:15 AM to 2:00 PM. Licensed Practical Nurse #5 stated the certified nurse aides scheduled to start at 6:00 AM had not yet arrived for their shift, and they were the only staff member on the unit at that time.During an observation and interview on 04/20/2026 at 7:09 AM, Licensed Practical Nurse #6 and Licensed Practical Nurse #7 were present on Unit 4. Licensed Practical Nurse #6 stated they were scheduled to work from 7:00 AM to 7:00 PM on and Licensed Practical Nurse #7 stated they were scheduled to work from 7:00 AM to 3:00 PM. Licensed Practical Nurse #6 and Licensed Practical Nurse #7 stated the three (3) scheduled certified nurse aides had not yet arrived for their shift on Unit 4.During a telephone interview on 04/21/2026 at 1:53 PM Registered Nurse #3 stated there were not enough staff in the facility at times and they just work with what they have. They stated that when there were three (3) or less certified nurse aides, they get any resident who was a feed assist or behavior up first. Registered Nurse #3 stated those residents were priority and the certified nurse aides would not have enough time to get up residents at their preferred time.During an observation and interview on 04/21/2026 at 4:15 PM, Resident #156's responsible party was assisting Resident #156 on the toilet. When they were finished, Resident #156's Responsible Party stated they were toileting Resident #156 because they could not find any staff on the unit to assist, which happened on a regular basis.During an interview on 04/21/2026 at 4:20 PM, Certified Nurse Aide #5 stated they worked the 2:00 PM to 10:00 PM shift and there were many times they were short staffed and could not get to residents' showers. They did the best they could, but it depended on who the other staff they were working with.During an interview on 04/21/2026 at 4:22 PM, Registered Nurse #4 stated some days were harder than others when staffing was short, the weekends especially. They stated certified nurse aides had complained about not being able to get to residents' showers when they were short staffed. During an interview on 04/22/2026 at 11:36 AM, Certified Nurse Aide #6 stated when there were only two (2) certified nurse aides they were only able to get to the important things for residents, like feeding and changing. They stated with three (3) aides, showers and the electronic medical record tracking were not always completed, nurses only helped if they had the time, which was not usually the case.During an interview on 04/22/2026 at 3:17 PM, Certified Nurse Aide #7 stated when there were three (3) or less aides on the unit, it was hard to get showers or charting done; some nurses would help or drop down to work as an aide, but not always.During an interview on 04/23/2026 at 11:10 AM, Certified Nurse Aide #11 stated staffing was horrible and it was worse on weekends. Sundays were their worst day. When they work with only two (2) aides they provide less care than normal; they try to get it all done but cannot. The supervisors do not take an assignment to work as aides. Some nurses help but do not take a full assignment and some nurses do not help at all. During a telephone interview on 04/20/2026 at 12:01 PM, the Registered Nurse Supervisor #1 stated they worked the 3:00 PM-11:00 PM shift, and that day shift had better staffing and evening shift barely had (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	two (2) certified nurse aides on each unit. The staff come and go and were not scheduled full shifts. They stated they were not sure if this was because deals were made when there were staffing holes to fill. The Registered Nurse Supervisor #1 stated they helped out on the floors when they could but if there are admissions or they need to send someone to the hospital or falls they were too busy to help. They stated they worked every other weekend, sometimes staffing was covered, but the majority if time it was not. They stated they did not know their minimum staffing numbers, but management did not seem concerned if there were two (2) certified nurse aides on each unit. They have not been told what specific numbers there should be; they were just told by another supervisor who trained them that they liked to see 4-5 aides per unit on day shift and 4 aides per unit on evening shift.During an interview on 4/22/2026 at 10:01 AM, the Administrator reviewed the Unit Assignments sheets and stated that on 03/22/2026 evening shift they had nine (9) certified nurse aides and that they did not meet their minimum staffing numbers. At 1:12 PM, the Administrator stated on 02/21/2026 evening shift they had nine (9) certified nurse aides plus two (2) that worked a half shift until 6:00 PM and no they did not meet their minimums. On 02/22/2026 day shift they had 10 certified nurse aides, and one (1) left at 11:00 AM and on 02/22/2026 evening shift a total of six (6) plus two (2) who worked half shifts and would consider it nine (9) because the nursing supervisor would work as an aide, but they did not meet their minimum staffing.During an interview on 04/23/2026 at 1:22 PM, the Administrator stated the carpets were something the facility was working on, but resident care was more important. Additionally, the Administrator stated they needed to ensure the facility was staffed properly because they had more complaints with staffing than the carpets. During an interview on 04/23/2026 at 1:39 PM, the Administrator stated they had been doing the staffing since January when the prior scheduler left. They determined the prior Director of Nursing allowed staff to work every 3rd weekend, not every other weekend, which was their policy. They did not know the prior Director of Nursing did this and they have since gone back to every other weekend. They have identified a lot of aides were coming in late, showing up when they wanted to and would work weekdays only to get full-time hours, but now they were enforcing weekend call-off make-ups. Also, if someone picks up a shift and then they call off that shift, they were no longer able to pick up shifts for two (2) weeks. The Administrator stated they have seen a decrease in call offs since this started. New York Codes, Rules, and Regulations (NYCRR) 415.13 (b)(1)(ii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review conducted during the survey, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, observations of one (1) of one (1) kitchen revealed active wastewater discharge in the main kitchen's dishwashing area; two (2) of two (2) walk-in freezer units had an accumulation of ice on interior wall surfaces, floors, and ceilings, and one (1) of two (2) walk-in refrigeration units had an accumulation of water on the floor.The findings include: The policy titled Kitchen, Dining and Dietary Equipment Routine Cleaning Policy, last revised 04/26/2019 documented the dietary work areas will be kept clean and in order by designated department according to routine schedules established by the Director of Dietary Services. The cleaning procedures will be planned and conducted in conformance with pertinent sections of the State Health Code, Rules and Regulations. The monthly cleaning schedule included but was not limited to the following: freezer and cooler, floors and racks, and all walls and doors. The policy titled Equipment, Systems Repair, last revised 11/22/2024 documented the Supervisor of Maintenance will be responsible for inspecting, repairing and maintaining the facilities non-moveable equipment and communication systems which will include but was not limited to plumbing, the refrigeration system, and kitchen equipment. The Supervisor of Maintenance will inspect the designated systems and equipment and perform the necessary repairs. Those systems included: plumbing - whenever possible this had to be done by department, but when problems were outside of the expertise and/or capability of the department the designated contractor was to be called. The policy titled Maintenance Repairs, last revised, 07/22/2025 documented the Maintenance Department Management would be responsible for building equipment repairs. The Manager/Supervisor will decide whether environmental services staff or outside agency will make needed repairs. The Maintenance Management assessed the extent of repairs needed, identified in work orders by the facility staff. In all instances of inside or outside source repair requests were documented in writing on the facility's TELS (a comprehensive building management platform used to manage maintenance, repairs, compliance, and asset tracking) system. 1. The plumbing contractor's invoice dated 03/31/2026 documented water jetting (a professional high-pressure drain cleaning method that uses pressurized water to blast through blockages in plumbing) was performed from the maintenance office hallway to the doorway by the kitchen, and then from the doorway by the kitchen down the hallway to the outside. A contractor's note revealed this service was to be performed annually on a non-emergency basis. The invoice documented confined space entry was conducted to water jet into the building from the Muffin Monster (a powerful dual-shafted sewage grinder designed to protect wastewater pumps by shredding various types of debris) pit, and then water jet from the meter pit to the municipal main line. The plumbing contractor's invoice dated 04/03/2026 documented the kitchen sewer line backed up, was snaked by the contractor, and camera service was subsequently provided to investigate the cause of the backup. The contractor found food grease, straws, and plastic blocking the sewer line. Additionally, the contractor advised the facility to use caution with items sent down kitchen drains. During observations and an interview on 04/15/2026 at 8:56 AM, [NAME] #1 was mopping the floor over the drain line by the dishwash area in the kitchen and there was a malodorous sewage-like smell. Further observation at this time revealed there was no visible debris on the floor and no contamination of food storage and food preparation surfaces. [NAME] #1 stated there was a backup with the drains both in the kitchen under the dishwash area and in the dishwashing room, and a plumbing contractor snaked the drains that morning. Additionally, [NAME] #1 stated it was not the first time a sewage backup had happened in the kitchen related to the disposal system. During an interview on 04/16/2026 at 8:49 AM, the Director of Plant Operations stated dietary staff had been told many times to not put grease and plastic wrap down the drain. Additionally, the Maintenance Director stated issues with the disposal in the kitchen were ongoing, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	occurring on a near-monthly basis, and they recently had the kitchen line jetted and snaked. During an interview on 04/23/2026 at 3:48 PM, the Administrator stated they were not aware of the waste disposal situation, nor were they aware of the ongoing disposal backups and issues with staff throwing inappropriate items into the disposal that were found to be causing the backups. The Administrator further stated every department head was responsible for informing them of issues in their department. 2. During observations on 04/15/2026 at 9:00 AM, the walk-in refrigeration unit within the kitchen had an accumulation of water on the floor, approximately 2-foot in diameter and 1/8th of an inch deep. Further observation revealed the adjacent walk-in freezer unit shared a wall with the walk-in refrigeration unit and had a significant accumulation of ice throughout the ceiling, walls, and floor. During an interview at the time of the observations, the Food Service Director stated the ice buildup in the walk-in freezer unit happened that past Monday, when food items were delivered and the freezer door was open during the delivery time frame. The Food Service Director further stated they could not provide a time estimate as to how long the walk-in freezer door remained open during the delivery. During observations on 04/15/2026 at 9:12 AM, the walk-in freezer unit within the walk-in refrigeration unit located in the dry storage room had an accumulation of ice behind fans, ventilation, and tubing. Further observation inside the walk-in freezer unit revealed the application of polyurethane-based insulating foam to an actively leaking pipe that was also surrounded by icicle formations. An additional observation at this time revealed the deflector to one (1) of one (1) pendant sprinkler head was loaded with icicles. During an interview on 04/15/2026 at 9:24 AM, the Food Service Director stated they most likely reported the issues with the walk-in freezer units last Summer, but they were unable to find the report in the TELS (a comprehensive building management platform used to manage maintenance, repairs, compliance, and asset tracking) system. During an interview on 04/16/2026 at 8:49 AM, the Director of Plan Operations stated they were not aware of the leak in the walk-in freezer unit within the walk-in refrigeration unit, the ice buildup in either of the two (2) walk-in freezer units, and the water pooling in the walk-in refrigeration unit in the kitchen. The Maintenance Director further stated their HVAC (heating, ventilation, and air conditioning) contractor performed work on the walk-in refrigeration units and walk-in freezer units in the past, but the facility did not maintain that documentation. During an interview on 04/23/2026 at 12:22 PM, the Maintenance Director stated their HVAC (heating, ventilation, and air conditioning) contractor was onsite to assess one (1) of two (2) walk-in freezer units. The Maintenance Director further stated the contractor planned to seal several components of the walk-in freezer unit and repair sections of the walls. Additionally, the Maintenance Director stated the contractor planned to also service the other walk-in freezer unit and two walk-in refrigeration units. During an interview on 04/23/2026 at 1:22 PM, the Administrator stated every staff member had access to the TELS (a comprehensive building management platform used to manage maintenance, repairs, compliance, and asset tracking) system, and anything maintenance-related was reported in this system. The Administrator further stated staff could even take a picture of the issue and complete the report over their phone, which would then be categorized by priority. During an interview on 04/23/2026 at 3:48 PM, the Administrator stated they found out that morning the walk-in freezer units had a buildup of ice, and dietary supervisors were supposed to let them know if there was an issue with equipment in the kitchen. 10 New York Codes, Rules, and Regulations (NYCRR) 415.14(h)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review conducted during an extended Standard survey completed on 04/23/2026, the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the administration did not ensure residents were free of accident hazards had adequate supervision and facility policies and protocols were consistently implemented and monitored for their effectiveness. This has the potential to affect all residents residing in the facility. The findings include: Review of the facility policy titled Resident Care Standards dated 10/22/2018 documented the Administrator will assure that standard of resident care was maintained at all times in accordance with the standards adopted by Medical Services Policy Committee. the Administrator was responsible for the provision of resident care in a manner and in an environment that promotes maintenance or enhancement of each residents' quality of life. Including providing all residents with an environment that was safe. Monitors that care which included: reviews of accident and incident reports, attending care planning meetings, maintaining contact with families, maintains communications with consultants and professional staff to assure that resident care planning was carried out, reviews of monthly reports, makes daily/scheduled rounds of the facility. REFER TO: F 689 - Free from Accident Hazards/Supervision/Devices, Scope and Severity G During an interview on 04/21/2026 at 8:29 AM, the Administrator stated they were not aware that care plan interventions were not updated for Resident #87. They expected the unit managers to update the care plans. They stated no unit managers had come to them with problems regarding this resident. They stated they did not think anything was wrong with the interventions in place. The Administrator stated falls can be potentially harmful, that was why they put interventions in place. When they run out of interventions they would have to do other things, like sit with the resident 24/7 but did not think this would help because the resident would also fall with a one to one (1:1) staff member.During an interview on 04/23/2026 at 12:23 PM, the Administrator stated the facility could have done a better job at auditing and following up with the smokers to make sure they were safe and not smoking close to the building. During an interview on 04/23/2026 at 12:41 PM, the Regional Nurse Consultant stated there was only a non-smoking policy and it did not apply to the current smokers at the facility. They stated there should not have been any smokers at the facility period. The smoking concerns or violations should have been directed to the Administrator, and the Administrator should have addressed the smoking. During a telephone interview on 04/23/2026 at 2:57 PM, the Chief Operating Officer stated the Administrator reports to them and were their direct supervisor. The Chief Operating Officer expected the Administrator to always keep the residents safe. There should not be anyone smoking and would expect the Administrator to make sure it did not happen. The policy committee met monthly, but not all policies were reviewed. Additionally, the Administrator should be working with the physician and the staff to ensure residents were safe. 10 New York Code Rules Regulations 415.26

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the survey, the facility failed to ensure a Quality Assurance and Performance Improvement (QAPI) program effectively developed and implemented appropriate plans of action to correct identified quality deficiencies related to resident safety with the potential to cause serious harm to residents. Specifically, the facility failed to implement effective systems to maintain resident safety. The findings include:Refer to F 689- Free of Accident Hazards/Supervision/Devices, Scope and Severity GThe facility policy and procedure titled QAPI (Quality Assurance and Performance Improvement) Program dated 03/18/2025 documented to assure development, implementation and maintenance of an effective, comprehensive, data driven Quality Assurance and Performance Improvement (QAPI) program that focuses on indicators of the outcomes of care and quality of life. The facility will undertake systematic analysis and action aimed at performance and improvement and, after implementing those actions, measure its success, and track performance to ensure that the improvements were realized and sustained. A systematic approach will be used to determine underlying causes, develop corrective actions to effect change to prevent quality care, quality of life or safety problems and improve activities to ensure that improvements were maintained. The Quality Assurance and Performance Improvement Committee will set priorities for the QAPI program and performance improvement activities that focus on; high risk, high volume or problem prone areas, and incidence, prevalence, and severity; those areas that affect the health outcomes, resident safety, resident autonomy, resident choice and quality of care will be considered and included.1. Resident #87 had diagnoses including progressive supranuclear ophthalmoplegia (a progressive neurodegenerative disease), orthostatic hypotension (a form of low blood pressure that occurs in a standing position), and repeated falls.Resident #87 had frequent and repeated witnessed and unwitnessed falls from 12/03/2025, through 04/20/2026. The facility failed to assess, implement and evaluate the effectiveness of safety interventions. As a result of the repeated falls, Resident #87 suffered multiple injuries such as bruising, cuts and abrasions. The resident also suffered pain, a left wrist fracture and non-displaced acute fracture of the lateral humeral condyle (elbow); fractures of their left 11th and 12th ribs; an avulsed component (occurs when a ligament or tendon pulls a small piece of bone away from the main bone, caused by sudden, high-tensile force) of the lateral humeral condyle; and a head injury with a change in condition (lethargy and changes in mentation) resulting in an admission to the hospital.On 01/14/2026 at 4:03 PM, resident's quality of life reviewed with interdisciplinary team today, the team feels it would be best to reassess activities of daily living to assure current care plan was appropriate. Resident #87 has no current recommendations at this time. On 01/27/2026 at 12:48 PM, a care plan meeting was held with the resident's spouse present. Nursing reviewed medications and medical status. There was no documentation that Resident #87's frequent falls, or safety interventions were re-evaluated or discussed. Review of an email dated 02/05/2026 at 12:17 PM, provided by the Administrator, Resident #87 was identified in a falls audit, and the Pharmacy Consultant reviewed their medications, and the Medical Director reviewed their chart. Review of an email dated 02/05/2026 at 12:17 PM, provided by the Administrator, Resident #87 was identified in a falls audit, and the Pharmacy Consultant reviewed their medications, and the Medical Director reviewed their chart. During an interview on 04/23/2026 at 1:31 PM, the Administrator stated they had monthly Quality Assurance meetings and met quarterly for Quality Assurance and Performance Improvement (QAPI). They stated they reviewed accident/incident reports from the previous twenty-four hours daily in morning report and discussed interventions for Resident #87, but they felt they had exhausted all options.2. Resident #116 had diagnoses including cerebral infarction (a stroke), aphasia (absence or difficulty with speech), and epilepsy (seizure disorder). The Minimum Data Set, dated [DATE] documented the (continued on next page)

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	335752	A. Building B. Wing	04/23/2026

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident used tobacco, the Minimum Data Set, dated [DATE] documented the resident had moderately impaired cognition.During an observation and interview on 04/15/2026 at 12:56 PM, Resident #116 stated they smoke outside all the time. They stated no staff supervise their smoking. Observation of the garbage can in their bathroom revealed one (1) cigarette butt was in the garbage can. The resident stated nobody told them where to put their butts. During an observation on 04/15/2026 at 2:47 PM, Resident #116 was in the courtyard next to the building and smoked a cigarette with no staff present. They put their cigarette out, placed the butt in their shoe, then left the courtyard area.During an observation and interview on 04/21/2026 at 12:10 PM, the Interim Director of Nursing stated Resident #116 was safe to smoke independently and kept their smoking items in their own possession. Residents were not supposed to smoke in the courtyard next to the building but believed they did smoke there. Nobody follows the residents outside to check where they were smoking. 3. Resident #30 had diagnoses including cerebrovascular disease (a group of conditions that interfere with blood flow to the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness), and hypertension (high blood pressure). The Minimum Data Set, dated [DATE] documented Resident #30 was usually understood, usually understands and was cognitively intact.Review of Resident #30's comprehensive care plan revealed there was no care plan development related to smoking. During an observation on 04/15/2026 from 2:16 PM through 2:22 PM, Resident #30 was approximately 13 feet away from the building in a patio area. Resident #30 lit a cigarette, smoked the cigarette, extinguished the cigarette on the wheel of their wheelchair, wheeled themselves to a garbage can and threw the extinguished cigarette butt in the garbage can. During an observation on 04/21/2026 at 12:59 PM, Resident #30 was approximately 17 feet from the entrance door. They were lighting up a cigarette. At 1:13 PM, Resident #30, extinguished their cigarette and wheeled themselves to one of the garbage cans in the patio area to the left of the building. During an interview on 04/22/2026 at 9:45 AM, the Interim Director of Nursing stated residents should not be smoking in the patio court yard area and they were all educated that this was a non-smoking facility. They stated that the smokers in the facility were non-compliant and should have been smoking by the benches near the road. During an interview on 04/23/2026 at 12:23 PM, the Administrator stated residents that smoked in the facility were educated. The Administrator stated the facility could have done a better job at auditing and following up with the smokers to make sure they were safe and not smoking close to the building. They stated there was no supervision on the patio at all unless a resident was someone who required supervision. During an interview on 04/23/2026 at 1:31 PM, the Administrator stated they had monthly Quality Assurance meetings and met quarterly for Quality Assurance and Performance Improvement (QAPI). The Administrator identified smoking as an issue. The Administrator stated Residents #30 and 116 were just going to do what they wanted as long as they were safe, there's was nothing much left they could do. During an interview on 04/23/2026 at 12:23 PM, the Administrator stated the facility was considered smoke free, so there was no policy for smoking. During an interview on 04/23/2026 at 12:41 PM, the Regional Nurse Consultant stated there was only a non-smoking policy and it did not apply to the current smokers at the facility. They stated there should not have been any smokers at the facility period. The smoking concerns or violations should have been directed to the Administrator, and the Administrator should have addressed the smoking. During a telephone interview on 04/23/2026 at 2:57 PM, the Chief Operating Officer stated they had identified a while ago there were residents smoking and they were educated to go off the property. 10 New York Code Rules and Regulations 415.27(a-c)

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Elderwood at Cheektowaga	225 Bennett Road Cheektowaga, NY 14227

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the survey, the facility failed to establish smoking policies in accordance with applicable Federal, State, and local laws regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. Specifically, one (1) of one (1) facility reviewed did not develop a smoking policy for residents who smoke and were not grandfathered in. This involved Resident #30 and #116. The findings include: REFER TO: F689 - Free from Accident Hazards/Supervision/Devices scope and severity G The facility policy titled Smoke Free Environment dated 10/30/2018 documented based on the Public Health Law, New York State Clean Indoor Air Act, smoking is prohibited in all areas inside the facility. A separate outdoor area may be designated on the ground (the area within the facility property lines) where smoking is permitted by residents/patients, visitors and guests, provided that the designated area was not within thirty (30) feet of any facility structure including any overhang, canopy, awning, entrance, exit, window, intake or exhaust. No Smoking signs will be displayed as needed in appropriate indoor/outdoor locations. Concerns/complaints or violations regarding the non-smoking policy at this facility should be directed to the Administrator. The Administrator in each facility has the authority to grandfather individual residents admitted prior to October 8, 2013 in order to allow supervised/unsupervised smoking privileges. A list of residents who smoke was provided by the facility on 04/15/2026 and documented that Resident #30 and Resident #116 were smokers. The list also documented the smoking location was a bench near the front entrance to the main campus (near the road). During the entrance conference on 04/15/2026 at 9:00 AM, the Administrator stated there were residents who smoke that resided at the facility. They stated there was no smoking policy because it was a non-smoking facility. Resident #116 had diagnoses including cerebral infarction (a stroke), aphasia (absence or difficulty with speech), and epilepsy (seizure disorder). The Minimum Data Set, dated [DATE] documented the resident used tobacco, the Minimum Data Set, dated [DATE] documented the resident had moderately impaired cognition. During an observation on 04/15/2026 at 2:47 PM, Resident #116 was in the courtyard/patio area next to the building smoking a cigarette. They put their cigarette out, placed the butt in their shoe and left the courtyard area. Resident #30 had diagnoses including cerebrovascular disease (a group of conditions that interfere with blood flow to the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness), and hypertension (high blood pressure). The Minimum Data Set, dated [DATE] documented Resident #30 was usually understood, usually understands and was cognitively intact. During an observation on 04/15/2026 from 2:16 PM through 2:22 PM, Resident #30 was approximately 13 feet away from the building in a patio/courtyard area when they lit a cigarette, smoked the cigarette, and extinguished the cigarette on the wheel of their wheelchair. They wheeled themselves to a garbage can and threw the extinguished cigarette butt in the garbage can. During an interview on 04/23/2026 at 12:23 PM, the Administrator again stated the facility was considered smoke free, so there was no policy for smoking. During an interview on 04/23/2026 at 12:41 PM, the Regional Nurse Consultant stated there was only a non-smoking policy and it did not apply to the current smokers at the facility. They stated there should not have been any smokers at the facility period. The smoking concerns or violations should have been directed to the Administrator, and the Administrator should have addressed the smoking. 10 New York Codes, Rules, and Regulations 415.29(a)(1)

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Elderwood at Cheektowaga	225 Bennett Road Cheektowaga, NY 14227

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review conducted during the survey, the facility did not ensure residents had the right to choose activities, schedules, and health care consistent with their interests, assessments, and plan of care for two (2) (Resident's #3 and #30) of five (5) residents reviewed for choices. Specifically, showers were not offered twice weekly as planned (Resident #3) and Resident #30 was not out of bed and in the dining room for all meals as planned as per their preference.The findings include: The facility policy and procedure titled Accommodation of Needs and Self Determination dated 04/10/2018 documented Residents/Patients at the facility will receive reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Residents will have the right to choose activities, schedules and health care consistent with his or her interests, assessments and plan of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life that are significant to the resident. The facility policy and procedure titled Hygiene and Grooming dated 02/07/2024 documented individual preferences of residents for personal care and grooming will be established and documented. Residents are offered a bath/shower weekly, or more often if preferred. 1.Resident #3 had diagnoses including hemiplegia (paralysis on one side of the body), weakness, and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 10/24/2025, documented Resident #3 was cognitively intact. Resident #3 required supervision or touching assistance for showering. The Minimum Data Set, dated documented that it was very important for Resident #3 to choose between a tub bath, shower, bed bath, or sponge bath. Review of the comprehensive care plan revised on 10/24/2024 documented Resident #3 had potential for alteration in their daily customary routine related to a new environment. The plan included Resident #3's bathing preference was two (2) times weekly and as needed. Saturday was the only shower day listed for Resident #3. Review of the Kardex (a guide used by staff to provide care) with an as of date of 04/22/2026 documented Resident #3's shower was scheduled weekly on Saturday. The Kardex did not reflect that Resident #3 preferred showers twice weekly. During an interview on 04/15/2026 at 11:31 AM, Resident #3 stated their showers were scheduled for Thursdays. Resident #3 notified Registered Nurse #5 Unit Manager that they preferred two (2) showers weekly, but they were lucky if they had one (1) shower per week when the staff could fit them in. The Unit two (2) Bathroom Schedule with a revised date 01/13/2026 and verified as the current shower schedule on 04/16/2026 by Registered Nurse #5 Unit Manager documented Resident #3 was scheduled to have a shower every Thursday on the 3:00 PM - 11:00 PM shift. Review of the Skin Check Shower Sheet on 04/22/2026 documented the last scheduled shower for Resident #3 was completed on 03/26/2026. There was no further documented evidence that Resident #3 received their showers twice weekly as planned. Review of the Progress Notes dated 03/01/2026 through 04/22/2026 revealed there was one (1) documented bed bath on 04/02/2026. During an observation and interview on 04/22/2026 at 10:03 AM, Resident #3 was fully groomed and sitting in their wheelchair just inside their room. Resident #3 stated showers were scheduled according to room numbers. During an interview on 04/22/2026 at 1:18 PM, Licensed Practical Nurse #2 stated showers were given based on the shower schedule created by Registered Nurse #5 Unit Manager. Residents previously received two (2) showers but that was changed back to once weekly and did not know why. During a telephone interview on 04/22/2026 at 1:48 PM, with Registered Nurse #2 Unit Manager they stated showers were scheduled according to room numbers. Activities completed the resident preference portion on the annual Minimum Data Set. No specific process was in place for the frequency. Nurses were responsible for completing skin checks when the certified nurse aides were giving the shower to hold them accountable. The skin sheets were kept in a binder for proof because (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	families complained that the residents were not receiving their scheduled showers. If a resident preferred more than one (1) shower they would have to let a nurse or aide know, then they notified them and they updated the care plan and the shower list. Registered Nurse #2 Unit Manager could not recall how many showers were scheduled weekly for Resident #3. When a resident was admitted to the facility, they informed them of their shower day based on the set schedule. During an interview 04/22/2026 at 2:30 PM, Registered Nurse #5 Unit Manager stated they recently took over as the unit manager for the floor. Showers were given according to the residents' room numbers set on the shower schedule. There was no specific process for asking how many showers a resident preferred just whether they chose between a shower, tub bath, or a bed bath. The Kardex, comprehensive care plan and the shower schedule should all match. During an interview on 04/23/2026 at 8:48 AM, Assistant Director of Nursing #1 stated residents could always request additional showers, and we would accommodate them. There should be a formal process for updating resident preferences and they should be reviewed quarterly during the care planning meeting but was unsure that was happening. It was Resident #3's right to have more than one (1) shower a week. During an interview on 04/23/2026 at 8:58AM, the interim Director of Nursing stated they would have expected Registered Nurse #5 Unit Manager to accommodate and honor Resident #3's request and adjust the shower list based on resident preferences. The Kardex and the comprehensive care plan should reflect the shower schedule and should be reviewed quarterly and as needed. They stated they expected Registered Nurse #5 Unit Manager to follow up with the residents regarding their preferences. During an interview on 04/23/2026 at 1:50 PM, the Administrator stated it was expected that resident preferences were honored. 2.Resident #30 had diagnoses including cerebrovascular disease (a group of conditions that interfere with blood flow to the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness), and hypertension (high blood pressure). The Minimum Data Set, dated [DATE] documented Resident #30 was cognitively intact. The comprehensive care plan dated 06/27/2022 documented Resident #30 had a potential for alteration in their daily customary routine related to long term placement. Interventions included rise time preference: 7:00 AM. The care plan was revised on 05/30/2024 an documented under nutrition was preferred dining location: UDR (unit dining room). Review of the Kardex (guide used by staff to provide care) dated 04/16/2026 documented Resident #30's preferred dining location: UDR (unit dining room) and rise time preference: 7:00 AM. Review of the Nursing Progress Notes dated 03/01/2026 through 04/19/2026 lacked documented evidence of Resident #30 refusing morning care, getting out of bed, or going to the dining room. During an interview on 04/15/2026 at 10:19 AM, Resident #30 stated nothing was consistent at the facility. They stated that they liked to get up and out of bed in the morning and there were times when they would be left in bed until after 11:00 AM. Resident #30 stated go ask the staff why they would leave them in bed so long, and they would say it was because they did not have enough staff. During an observation on 04/16/2026 at 10:18 AM, Resident #30 was lying in bed, wearing a hospital gown. At this time Resident #30 stated they liked to be out of bed between 7:00 AM and 7:30 AM. They stated it was well past that time and even if the staff had gotten them out of bed so they could have eaten breakfast in the dining room, that would have been ok. Resident #30 stated they had told the certified nurse aide they wanted to get out of bed earlier. During a continuous observation on 04/17/2026 at 8:39 AM, Resident #30 was sitting up in bed, wearing a hospital gown, eating a bagel and cream cheese. At this time Resident #30 stated, I told you; they do not get me up when I want to get up and I'm stuck eating in bed again. At 9:26 AM, Certified Nurse Aide #3 took supplies and the sit to stand lift into Resident #30's room. At 9:30 AM, Resident #30 was dressed and up in their wheelchair. They wheeled themselves into their bathroom as Certified Nurse Aide #3 brought the sit to stand lift out of the room. During an interview on 04/17/2026 at 9:31 AM, Certified Nurse Aide #3 stated all residents were different when it came to when they got out of bed. They stated a lot of the time, what time residents got up depended on staffing. Certified Nurse Aide #3 stated they have seen on one (1) or two (2) resident care plans that certain residents wanted to get (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up at certain times. They stated they were not aware that Resident #30's care plan documented that they wanted to get up at 7:00 AM and since it was their preference, they should have been up closer to 7:00 AM and not 9:30 AM. Certified Nurse Aide #3 stated the unit was not consistent with how often the dining rooms were used because of staffing. They stated when there were three (3) or less certified nurse aides on the unit, the assignments were too heavy to get residents up and to the dining room. During an interview on 04/21/2026 at 12:34 PM, Certified Nurse Aide #4 stated the care plan would document when a resident prefers to get up in the morning and if they preferred to eat in the dining room. Certified Nurse Aide #4 stated the care plan should be checked before care because they change a lot. They stated that if a resident wanted to be up at 7:00 AM, they should get up as close to that time as possible. They stated it was the certified nurse aides' responsibility to read resident care plans and to follow them. During a telephone interview on 04/21/2026 at 1:53 PM, Registered Nurse #3 stated there were not enough staff in the facility, at times and they just work with what they have. They stated that when there were three (3) or less certified nurse aides, they get any resident who was a feed assist or behavior up first. Registered Nurse #3 stated those residents were priority and the certified nurse aides would not have enough time to get up residents at their preferred time. During an interview on 04/22/2026 at 8:38 AM, Licensed Practical Nurse #4 Unit Manager stated it was their expectation that the certified nurse aides look at the care plan/Kardex daily and review the sections: safety, fall interventions, mobility, and customary/preferences. They stated that Resident #30's preferred dining location was listed as UDR meaning in the unit dining room. Sometimes the certified nurse aides were running late and staffing varied day to day, but the dining rooms should still be used. Licensed Practical Nurse #4 Unit Manager stated Resident #30 prefers to be up between 7:00 AM and 8:00 AM and normally the staff do get Resident #30 up before 10:30 AM. They stated Resident #30 enjoys going to the dining room for all meals. During an interview on 04/22/2026 at 9:45 AM, the Interim Director of Nursing stated they expected certified nurse aides to read and follow the care plans for the residents on their assignment. They stated if a resident preferred to get up at 7:00 AM, they should be up as close to 7:00 AM as possible. The interim Director of Nursing stated the units were supposed to use the dining rooms. If a resident wanted to be in the dining room for their meals, then they should be in the dining room. The interim Director of Nursing stated the residents in the facility had the right to voice their preferences and the preferences should have been followed as much as possible. The unit managers were responsible for making sure the staff on the unit were following the care plan. During an interview on 04/23/2026 at 9:54 AM, Diet Technician #1 stated they had completed the portion of the care plan that included dining preferences. They stated Resident #30 was a very social resident and enjoyed eating in the dining room. Since Resident #30 prefers the dining room for all meals, staff should follow that preference. During an interview on 04/23/2026 at 12:23 PM, the Administrator stated it was expected that staff on the unit follow the care plan. 10 New York Code Rules Regulations 415.5 (b) (1,3)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interview, and record review conducted during the survey, the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for one (1) (Resident #102) of six (6) residents observed for activities of daily living care provided to dependent residents. Specifically, Resident #102 was observed on multiple occasions with greasy hair and there was no documented evidence they received their scheduled showers.The findings include:The facility policy Hygiene and Grooming last revised 02/07/2024 documented designated nursing staff would ensure that resident were always clean and appropriately groomed. The individual preferences of residents for personal care and grooming would be established and documented. Residents would be provided with care to maintain or improve abilities to perform hygiene and grooming tasks, as needed. Bath/shower scheduled and services: the preferences or care plan for bathing were recorded on the Interdisciplinary Profile of Care. Residents were offered a bath/shower weekly, or more often if preferred or needed, as follows. Hair was combed with morning care and as necessary to maintain an attractive and well-groomed appearance. A shampoo was given with the regularly scheduled bath/shower unless service was contraindicated or provided by the beautician/barber. All refusal care was documented in the computerized point of care system and verbally reported to the Team Leader/designee.The facility policy titled Activities of Daily Living Assistance and Supervision last revised 01/04/2018 documented the Unit Manager would ensure that a plan of care for receiving activities of daily living assistance and/or supervision was incorporated into the daily nursing care of each resident, they would ensure that the activities of daily status of each resident was monitored on an ongoing basis.Resident #102 had diagnoses including vascular dementia without behavioral disturbances, aphasia (difficulty speaking), and dysphagia (difficulty swallowing), The Minimum Data Set (a resident assessment tool) dated 02/03/2026 documented Resident #102 was severely cognitively impaired, usually understands and was usually understood by others. The resident was dependent on staff for showers.The comprehensive care plan revised 03/27/2026 documented Resident #102 had an activities of daily living deficit related to function/mobility and recent hospitalization. The resident required a maximal assist of one staff for their upper body and lower body dressing. Resident #102's bathing schedule was Wednesday day shift (6:00 AM to 2:00 PM).Review of Documentation Survey Report dated April 2026 documented Resident #102's bathing schedule, with blanks on Resident #102s scheduled shower dates (04/01/2026, 04/08,2026, 04/15/2026, and 04/22/2026).There was no documented evidence that Resident #102 received their scheduled showers on the dates planned.During multiple intermittent observations on 04/16/2026, at 3:50 PM Resident #102 had greasy disheveled hair; on 04/17/2026 at 12:10 PM, 04/20/2026 at 8:33 AM, and 04/22/2026, Resident #102 had greasy, slicked back hair.During an interview on 04/22/2026 at 8:57 AM, Licensed Practical Nurse #7 stated they would click off on a resident's skin check after the aide gave the resident a shower, but could not recall if Resident #102 received a shower on 04/15/2026 or any other day.During an interview on 04/22/2026 at 11:32 AM, Certified Nurse Aide #6 stated they were Resident #102s assigned aide on 04/15/2026 and they could not recall if they gave Resident #102 a shower that day. Certified Nurse Aide #6 stated if there was no documentation in the computer system under bathing for Resident #102s shower day then there was no way to prove a shower was given. There were no shower sheets to fill out or to sign off on. They stated it was important for all residents to get their scheduled showers because it was their right. Additionally, Certified Nurse Aide #6 stated the residents hair was greasy.During an interview on 04/22/2026 at 12:45 PM, Registered Nurse #5 Unit 4 Manager stated the only documentation they had to ensure residents received their showers on the unit was the cart nurses' weekly skin examination, but that did not explicitly say the resident received a shower, and they expected Certified Nurse Aides to document in the computer system. If the care tracker was blank, there was no way to say the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents got their shower. Registered Nurse #5 stated it was important for hygiene purposes for residents to receive their showers on their scheduled days, it was their right.During an interview on 04/23/2026 at 12:45 PM, the interim Director of Nursing stated they would expect staff to offer residents their showers on the residents scheduled shower day, and it should be documented in the computer system care tracker. If the residents declined, then they expected that to be documented as well. The interim Director of Nursing stated it was important to respect residents' dignity and rights. 10 New York Code Rules and Regulations 415.12 (a)(3)

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	04/23/2026

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review conducted during the survey, the facility did not ensure that all residents received treatment and care in accordance with professional standards of practice and the comprehensive centered care plan for one (1) (Resident #162) of one (1) resident reviewed. Specifically, there was a lack of communication between staff when Resident #162 was admitted to the facility resulting in delayed admissions processes which included physician's orders, assessments and meeting the needs of the resident.The findings include:A booklet provided by facility titled Your Rights as A Nursing Home Resident in New York State dated 2022 documented as a resident in the facility, you have the rights guaranteed to you by state and federal laws. The facility was required to protect and promote your rights. You have the right to be cared for in a manner that enhances your quality of life and receive adequate and appropriate care.The facility policy titled Nursing Assessment/ Evaluation Requirement & Schedules last modified 02/03/2023 documented the facility would conduct assessments and evaluations upon admission/readmission and on a routine basis to assist in development/review or revision of the comprehensive care plan.The facility policy titled Resident Care Standards last revised 10/22/2028 documented the Administrator would assure that standards of resident care were maintained at all times in accordance with the standards adopted by the Medical Services Policy Committee. The job description titled Nursing Supervisor last revised 04/2021 documented the Nursing Supervisor assisted with ensuring the health and well-being of the residents by being responsible for nursing care rendered at the facility during the assigned shift. Essential job functions consisted of but were not limited to ensuring and/or assisted in performing accurate; thorough and timely completion of nursing admission evaluations and re-evaluations of patient/resident care needs in accordance with nursing department standards of practice.The job description titled Registered Nurse Team Leader last revised 01/2025 documented essential job functions consisted of but were not limited to assisting in performing accurate thorough and timely completion of nursing admission evaluation and re-evaluations of patient/resident care needs in accordance with nursing department standards of practice.Resident #162 was admitted with diagnoses including iron deficiency anemia secondary to blood loss, adult failure to thrive, and dyspnea (difficulty breathing); had a recent history (12/22/2025) of acute respiratory failure with hypercapnia due to Covid-19 and MRSA (methicillin resistant staphylococcus aureus - an antibiotic-resistant bacteria) pneumonia. The Minimum Data Set (a resident assessment tool) dated 01/26/2026 documented Resident #162 was cognitively intact and received oxygen therapy while a resident in the facility.Review of Grievance form dated 02/17/2026 completed by Resident #117s Responsible Party documented that Resident #117 arrived at the facility around 2:00 PM and was not properly admitted or assessed in a timely manner. Review of facility investigation dated 02/17/2026 revealed Resident #162 arrived at the facility at 1:50 PM via stretcher, was greeted by Receptionist #1 who received the admission paperwork. Resident #162 was taken up to Unit 4 and placed in bed by the paramedics. Certified Nurse Aide #16 and Certified Nurse Aide #17 greeted Resident #162, changed their clothing, brief, and made them comfortable. Resident #162 arrived with oxygen via nasal canula from a mini transport tank provided by the hospital and was not in any distress. Resident #162's Responsible Party arrived at the facility at 3:15 PM and met with Social Worker #2. Resident #162 was not in any distress at that time. At 3:18 PM, Resident #162's Responsible Party met with Registered Nurse #5 Unit Manager (unit 4), who discussed the difference between long term care and subacute rehabilitation, then Registered Nurse #5 left for the day. At 3:24 PM, Resident #162's Responsible Party went back to Resident #162's room. At 6:01 PM, Resident #162's Responsible Party approached Licensed Practical Nurse #5 and stated Resident #162 was in pain. Licensed Practical Nurse #5 arrived in the room and Resident #162 stated they were having trouble breathing. Licensed Practical Nurse #5 checked Resident #162's oxygen level, which was 58% and noted the oxygen tank was reading in the red (empty). A new oxygen tank was retrieved and applied to Resident #162 and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their oxygen level went up to 90%, Registered Nurse #2 Unit Manager/Nursing Supervisor was called to assess. Registered Nurse #2 former Unit Manager (unit 2) was working as nursing supervisor from 3:00 PM to 7:00 PM, oversaw admissions for the evening and was not aware Resident #162 was in the facility. Review of progress note dated 02/17/2026 at 9:54 PM, Assistant Director of Nursing/ Infection Preventionist (former Unit 1 Unit Manager) documented at 6:33 PM they were notified of Resident #162's Responsible Party being upset and it was requested they speak with them. Assistant Director of Nursing documented they went to assess Resident #162 at approximately 6:41 PM and when they entered the room, Resident #162 was lying supine (flat) with their eyes closed, oxygen mask on at five (5) liters, and chest heaving. Resident #162's Responsible Party stated Resident #162's oxygen level was in the 50's originally and they did not know how long the oxygen tank had been empty. Another family member arrived and was able to walk around the unit and find a staff member, Licensed Practical Nurse #5 got a new oxygen tank and applied it to Resident #162, bringing their oxygen level up to 90%. Licensed Practical Nurse #5 confirmed this and stated they did not know Resident #162 was even on the unit as they were not in the system yet. Upon assessment, Resident #162s fingertips were bluish-purple in color, respirations were labored with tachypnea (fast breathing rate) at 30 breaths per minute. Resident #162 did not verbally respond to questions or tactile stimulation, but after a few minutes and a sternal rub, Resident #162 did open their eyes. Assistant Director of Nursing documented they increased the oxygen rate to six (6) liters and re checked Resident #162 vital signs which were all within normal limits and were back to their baseline. Registered Nurse #2/ Nursing Supervisor entered the room at that time to complete the admission process and stated they would notify the on-call provider. History and physical notes completed by Nurse Practitioner #1 dated 02/18/2026, documented Resident #162 was seen for acute decline following recent hospital discharge, including persistent hypoxia which required supplemental oxygen, severe dysphagia (difficulty swallowing) with high aspiration (choking) risk, decreased level of alertness, and inability to safely tolerate oral intake or participate in therapy. Nursing documented episodes of severe oxygen desaturation, increased confusion, shallow breathing, difficulty speaking, and difficulty opening eyes. Given Resident #162's advanced age, multiple comorbidities (atrial fibrillation (irregular heart rate), chronic anemia, valvular heart disease (one or more of the hearts four valves fails to open or close properly, disrupting blood flow), Stage 3 sacral pressure ulcer (wound characterized by full thickness skin loss with subcutaneous (fatty tissue layer) tissue present), poor physiologic reserve and rapid decline, prognosis was discussed with Resident #162's family. A goal of discussion was held, including review of current condition, expected trajectory, risks of continued aggressive interventions and comfort focused alternatives. Family elected to transition to comfort measures only (conservative, supportive measures to be provided at the end of life). During an interview on 04/20/2026 at 11:15 AM, Licensed Practical Nurse #5 stated they started their shift at 3:00 PM on 02/17/2026 and were not made aware they had a new admission. They stated around 6:00 PM they were approached by Resident #162s responsible party who stated their family member needed help. They asked who the resident was and were confused because they did not have a resident in that room that they were aware of. Licensed Practical Nurse #5 stated they ran down to the room and checked Resident 162, their oxygen tank was in the red and their oxygen level was reading 58 percent. They stated they grabbed a new oxygen tank and called Registered Nurse #2 Nursing Supervisor who then came up to assess Resident #162. During a telephone interview on 04/21/2026 at 12:23 PM, Registered Nurse #2 Unit Manager/Nursing Supervisor stated they were working as the Nursing Supervisor on 02/17/2026 from 3:00 PM to 7:00 PM, had three (3) admissions total that day. They stated they were working on another admission when they were called over the intercom to come and assess Resident #162. Registered Nurse #2 stated the paperwork was normally given to the receptionist who would send the e-mail regarding the resident's arrival, but they were busy and did not have time to check their e-mail and were unaware Resident #162 had arrived. They stated that when Licensed Practical Nurse #5 notified them of Resident #162's low oxygen level, they (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed Resident #162, their mini transport oxygen tank was completely empty, and the responsible party had stated they had been in the facility for four (4) hours. Resident #162's oxygen level returned to normal after new oxygen was applied, and they were moved down to Unit 1 per the family request. During an interview on 04/21/2026 at 1:44 PM, Certified Nurse Aide #16 stated they assisted Certified Nurse Aide #17 with changing Resident #162 upon their arriving at the facility on 02/17/2026 around 1:45 PM, their shift ended at 2:00 PM. They were unaware if Certified Nurse Aide #17 reported to anyone that Resident #162 was in their room.During an interview on 04/21/2026 at 1:55 PM, Registered Nurse #5 Unit Manager (unit 4) stated the evening nursing supervisor was responsible for completing new admissions and on 02/17/2026. They sent a group text to all Nursing Supervisors letting them know there was admissions coming to the facility that day and they would need to be completed because they left at 3:00 PM. Registered Nurse #5 stated Registered Nurse #2 replied they would complete the admissions. Registered Nurse #5 stated they met Resident #162's Responsible Party on Unit 1 around 3:00 PM and walked them up to Unit 4, explained the transition from subacute to long term and then left for the day. They were unaware if Licensed Practical Nurse #5 or Registered Nurse #2 were aware Resident #162 was in the facility when they left for the day (3:00 PM).During an interview on 04/22/2026 at 8:51 AM, Certified Nurse Aide #17 stated Resident #162 was admitted to Unit 4 around 1:50 PM, they got them in bed, changed their clothing and brief, and then their shift ended. They could not recall if they let anyone know Resident #162 was in the room.During an interview on 04/22/2026 at 8:59 AM, Licensed Practical Nurse #6 stated they were not made aware Resident #162 had arrived at the facility at 1:50 PM (worked cart 7am-3pm); they stated the communication could have been better.During a follow-up interview on 04/22/2026 at 9:02 AM, Registered Nurse #5 Unit Manager (Unit 4) stated there was a delay in Resident #162 getting the oxygen they needed; there should have been someone aware that Resident #162 was in their room in the facility so that prompt care could have been provided. During an interview on 04/22/2026 at 10:14 AM, Assistant Director of Nursing (former Unit 1 unit manager) stated they were familiar with Resident #162 and their responsible party, so when Resident #162 readmitted to the facility, their responsible party came to see them and questioned why they were put on Unit 4. They stated Registered Nurse #5 Unit Manager was on Unit 1 at the time, so they introduced them to Resident #162's responsible party and gave Registered Nurse #5 report on Resident #162. Social Worker #2 came by and spoke with Resident #162'ss Responsible Party, and they went up to Unit 4 together. Assistant Director of Nursing stated they went into a meeting for about an hour and when they came out, Resident #162's Responsible Party was on Unit 1 again looking for a staff member because they could not find one on Unit 4. They stated Registered Nurse #5 happened to be on Unit 1, so they asked them to address Resident #162'ss Responsible Parties concerns and went into another meeting. After their meeting, an hour later they received a call from the Director of Nursing asking them to go to Unit 4 and speak with Resident #162's responsible party because they were upset about an issue with oxygen. They stated they went upstairs right away and Licensed Practical Nurse #5 was hooking Resident #162 up to a new oxygen tank and stated Resident #162's oxygen level was very low, and they were struggling to breathe, was not responsive. They bumped the tank up to five (5) liters and Resident #162's oxygen level rose quickly to 92 percent, and they were no longer in distress. Assistant Director of Nursing stated they spoke to everyone after and Licensed Practical Nurse #5 stated they were never made aware the admission was in the room, Registered Nurse #2 stated they were never made aware the admission was in the facility and had not had time to check their e-mail because they were busy. Receptionist #1 stated they did not know the admission arrived. They stated there was a large lack of communication which led to a delay in care. They expected staff to start admission processes right away so that initial assessments could be started within an hour. During an interview on 04/22/2026 at 12:23 PM, Receptionist #1 stated there were multiple admissions that arrived at the same time on 02/17/2026, so it was possible they forgot to bring Resident #162's admission paperwork to the nursing supervisors office when they arrived, but they could not recall (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exactly.During a telephone interview on 04/23/2026 at 11:29 AM, former Assistant Director of Nursing /the former interim Director of Nursing (2/17/2026) stated there was a miscommunication issue which led to Resident #162 not being assessed in a timely manner to meet the resident's needs. They stated they would have expected Registered Nurse #5 or Receptionist #2 to have relayed to Registered Nurse #2 that Resident #162 was in the facility so that the admission process could have been started and Resident #162 could have been assessed in a timely manner.During an interview on 04/23/2026 at 12:33 PM, current interim Director of Nursing stated they would have expected a better hand off of Resident #162 from paramedic to facility, from nurse to nurse, from shift to shift. They stated all around there was poor communication; if any party knew Resident #162 was in the facility, they should have informed someone on Unit 4 so that Resident #162 could have received the care they needed. They would have expected Resident #162 to have their admission assessment completed within an hour of arriving at the facility. 10 New York Code Rules and Regulations 415.12

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review conducted during the survey, the facility failed to provide pain management to residents who require such services, consistent with standards of practices, the comprehensive person-centered care plan, and the resident's goals and preferences for one (1) (Resident #69) of one (1) resident reviewed for pain management. Specifically, Resident #69 did not receive their pain medication in a timely manner on 04/17/2026. The findings included: The facility policy titled Pain Management, dated 03/17/2025, documented the facility shall provide adequate management of pain to ensure that residents attain or maintain the highest practicable physical, mental and psychosocial well-being. Chronic Pain refers to pain that typically lasts greater than three (3) months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown case. The purpose of pain management was to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Ongoing evaluation of pain management techniques will occur daily by the interdisciplinary team. Resident #69 had diagnoses that included multiple sclerosis (a chronic, autoimmune disease of the central nervous system), chronic pain syndrome, and paraplegia (paralysis affecting the lower half of the body). The Minimum Data Set (a resident assessment tool), dated 03/20/2026, documented the resident had an intact cognition level, understood and understands, and received scheduled and PRN (as needed) pain medication regimen for frequent severe pain that frequently interfered with day-to-day activities. The comprehensive care plan initiated 10/25/2024, documented Resident #69 had pain or had the potential of an alteration in their comfort related to chronic physical disability with interventions to assess characteristics of pain: location, severity on a scale of zero (0) - ten (10), type, frequency, precipitating factors, alleviating factors and vital signs or non-verbal indications of pain as needed; to assist resident to meet their functional goals; to complete pain evaluation per policy; to reassess and adjust plan to optimize pain relief as needed; to teach resident to request analgesics/non-pharmacological methods before pain becomes severe; and to clarify misconceptions about addictions to pain medications. The Kardex (a guide used by staff to provide care) dated 04/17/2026, documented Resident #69 could not walk, required substantial or maximal assistance for bed mobility, was totally dependent for chair/bed-to-chair transfer, required partial or moderate assistance for upper body dressing, and was totally dependent for lower body dressing. Review of the Order Summary Report dated 04/22/2026 documented Resident #69 had orders dated 02/09/2025 for pain evaluation every shift for pain monitoring, and Hydrocodone-Acetaminophen (an opioid analgesic) and acetaminophen (Tylenol) used to relieve moderate to severe pain) oral tablet 10-325 mg (milligrams) given one (1) tablet by mouth every six (6) hours as needed for pain. During an observation and interview on 04/17/2026 at 2:56 PM, Resident #69 was lying in bed and stated they had asked Certified Nurse Aide #22 for their Norco (an opioid analgesic) and acetaminophen (Tylenol) used to relieve moderate to severe pain) pain pill at 2:15 PM but had not received the pain pill yet. Review of the medication administration record, dated 04/2026, documented Resident #69 received Hydrocodone-Acetaminophen oral tablet 10-325 mg (milligrams) on 04/17/2026 at 3:45 PM and had a pain level of (seven) 7. During an interview on 04/17/2026 at 3:29 PM, Certified Nurse Aide #22 stated Resident #69 requested their pain medication between 2:00 PM and 2:15 PM this afternoon. Certified Nurse Aide #22 stated they were not sure which licensed practical nurse was currently working on their unit, but they knew a specific nurse was coming in at 3:00 PM. Certified Nurse Aide #22 further stated they were going to wait until 3:00 PM to inform the oncoming licensed practical nurse about Resident #69's pain pill request. During an interview on 04/17/2026 at 3:35 PM, Licensed Practical Nurse #9 stated they received the pain pill request from Certified Nurses' Aide #22 a few minutes prior to the interview. Licensed Practical Nurse #9 stated they had been working on the unit since 7:00 AM and did not know why Certified Nurse Aide #22 was (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	waiting for a different licensed practical nurse to inform of the resident's pain pill request. During an interview on 04/17/2026 at 3:50 PM, Licensed Practical Nurse #9, stated it was important to give pain medication to a resident in a timely manner to prevent pain from getting worse, causing further damage, and to stop the resident from being in pain. Additionally, Licensed Practical Nurse #9 stated Resident #69 received their pain pill at 3:45 PM, and their pain scale was 7/10 (seven out of ten) when their pain assessed at the time of administration. During an interview on 04/17/2026 at 3:55 PM, Certified Nurse Aide #22 stated residents' pain medication should be received shortly after being requested, and it was important for residents to receive their pain medication, so they were not sitting in agony. Certified Nurse Aide #22 further stated as a certified nurse aide, they did not assess via the pain scale but had asked how the resident was feeling. Additionally, Certified Nurse Aide #22 stated they knew their residents on the unit, and Resident #69 usually requested their pain medication around 2:15 PM and 9:00 PM. Furthermore, Certified Nurse Aide #22 stated they knew Licensed Practical Nurse #9 was present on the unit, but they (Certified Nurses' Aide #22) probably got busy with something which was why they did not tell Licensed Practical Nurse #9 about the resident's pain medication request. 10 New York Codes, Rules, and Regulations (NYCRR) 415.12

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interview conducted during the survey, the facility failed to ensure Certified Nurse Aide performance reviews were completed once every 12 months per year for three (3) (Certified Nurse Aides #3, #9, #10) of five (5) reviewed. Specifically, there was no evidence Certified Nurse Aides #3, #9, #10, who had worked for the facility more than 12 months had performance reviews completed at least once every 12 months.The findings include:The policy and procedure titled In-Service Attendance Program dated 07/19/2023 documented all staff/workforce will be expected to attend mandatory and non-mandatory in-service programs. Administrators were responsible for ensuring all employees and contractors attend annual mandatory training. At the time of the annual job performance review of a staff member, the evaluating manager will take into consideration as to whether or not the staff member was in compliance with mandatory in-service attendance.Review of the In-Service Education Record Binder on 04/23/2026 at 1:00 PM revealed Certified Nurse Aide #3's last annual competency skills evaluation was on 08/28/2024. There was no documented evidence of an annual competency completed in 2025. There was no evidence of an annual competency skills evaluation for Certified Nurse Aide #9. The most recent annual competency skills evaluation for Certified Nurse Aide #10 was 06/26/2024; there was no evidence of an annual competency completed in 2025.During an interview on 04/23/2026 at 9:50 AM, the Administrator stated Educator #1 was the Educator in 2025 and they did not do any annual staff competencies. They stated both themselves and the former Director of Nursing oversaw Educator #1. The Administrator stated they never had any role in reviewing if the annual competencies were completed because they trusted Educator #1 to complete them.During a telephone interview on 04/23/2026 at 10:08 AM, Certified Nurse Aide #9 stated they have worked at the facility since 2009. They stated that the staff educator at the facility was the one who normally completed annual evaluations, and they did not remember having any annual evaluation completed in 2025. They stated the facility had not had a steady staff educator for a while. Whenever there was a staff educator, they were pulled to do other things or were only in the position for a short time.During a telephone interview on 04/23/2026 at 10:26 AM, Educator #1 stated annual evaluations for staff were done informally. They stated there would be documentation for any annual evaluation that was done, and they could not say that they completed every staff member's evaluation. They stated it was the educator's responsibility to complete annual evaluations but there were other managers who could have worked with the educator on completing them.On 04/23/226 at 11:25 AM, a telephone call was placed, and a voicemail was left for the former Director of Nursing. There was no return telephone call received.During an interview on 04/23/2026 at 12:23 PM, the Administrator stated that it was the expectation that annual competencies were completed for certified nurse aides because some staff get into bad habits and this would keep those staff members on the right path. They stated if the annual competency was not in the In-Service Education Binder, then they did not think that the competency was completed. Educator #1 was responsible for completing staff competencies in 2025 until they left the position in November 2025. The interim Director of Nursing was hired as the staff educator in January of 2026 until they transitioned into the interim Director of Nursing role in late February/early March 2026. They stated after Educator #1 left the position; there was no staff educator in the interim until the Interim Director of Nursing was hired.10 New York Codes, Rules, and Regulations 415.26 (d)

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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 observation, interview and record review conducted during the survey, the facility failed to maintain drugs and biologicals labeled in accordance with currently accepted professional standards, and include the appropriate accessory and cautionary standards, and expiration date when applicable for one (1) of four (4) resident units reviewed for medication storage. Specifically, the facility failed to ensure the safe and secure storage of medications. The Unit four (4) South medication cart was not locked and under the direct view of authorized staff. The computer system on the cart had visible patient health information displayed in an area where residents, staff, and visitors had access. Resident #75 was involved. Additionally, the Unit four (4) medication refrigerator had one (1) opened multidose vial of Tuberculin Purified Protein Derivative (Mantoux) solution that was opened on 12/13/2025 and not discarded after twenty-eight days and one (1) opened bottle of Humalog (insulin lispro injection) medication without an opened date that was not discarded after twenty-eight days. The findings include: The facility policy and procedure titled Medication Carts dated 08/28/2024 documented medication carts will be locked when not in use or within direct view. Confidentiality of patient/resident information will be maintained at all times. All medications requiring date when opened will be properly labeled and discarded according to the manufacturer's recommendation. The facility policy and procedure titled Resident Care Standards dated 10/18 documented the Administrator will assure that standards of resident care are maintained at all times. New York State Department of Health, Your Rights as a Nursing Home Resident in New York State dated 2022, documented residents have the right to: Confidentiality concerning your personal and medical information; Privacy and confidentiality regarding medical, personal and financial affairs. Resident #75 had with diagnoses including end stage renal (kidney) disease, diabetes mellitus, and hypertension. The Minimum Data Set (a resident assessment tool) dated 02/13/2026 documented Resident #75 was cognitively intact, understands and was understood by others. During an observation on 04/15/2026 at 4:10 PM Registered Nurse #6 walked fifty feet down the south hall on Unit four (4) into Resident #75's room and the South hall medication cart unlocked and unattended or in view until 4:17 PM. Resident #75 personal medical information was displayed on the electronic medical record screen in plain view. During this time an unidentified resident walked from Unit three (3) was in the vicinity and visitors had passed by. There were no medications taken and no one stopped to view the resident's information. During an interview on 04/15/2026 at 4:17 PM, Registered Nurse #6 stated Resident #75 was ill and had to quickly get their vital signs. They stated, leaving the computer screen openly displayed, violated the Health Insurance Portability and Accountability Act (HIPPA) and they should have locked the screen and the cart because so that they were not in view. Wandering residents or staff could have accessed the medications in the cart which was unsafe. During an interview on 04/15/2026 at 4:25 PM, Registered Nurse #5 Unit Manager stated only the nurse should have access to the medications in the cart and personal resident information on the screen. A wanderer could have easily been capable of opening the drawers on the medication cart and if left unsupervised could have potentially ingested something that could hurt them. Registered Nurse #6 should have locked the cart, locked the screen or kept the cart in their view. During an observation on 04/20/2026 at 11:25 AM the Unit four (4) medication room refrigerator contained: one (1) opened multidose vial of Tuberculin Purified Protein Derivative solution labeled with an opened date of 12/13/2025 on the box; and one (1) unlabeled opened multidose vial of Humalog insulin. The pharmacy stickers on the bottles each had directives to discard after twenty-eight days of opening.During an interview on 04/20/2026 at 11:30 AM, Licensed Practical Nurse #2 stated the Tuberculin Purified Protein Derivative solution was opened on 12/15/2023 and the insulin did not have a date when it was punctured/opened and should have. They both should have been discarded twenty-eight days after opening because it was no (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	longer effective and should not be used. All nurses were responsible for checking dates every shift. During an interview on 04/22/2026 at 8:47 AM, the interim Director of Nursing stated in addition to the cart, the electronic medical record should have been secured in a common area where no one could access it and was basic nursing practice. The overnight nurse was responsible for checking the medication rooms weekly for expired medications. All nurses were responsible for checking each medication they administered for the expiration date. Expired or outdated medications should be given to the nursing supervisor to be disposed of. During an interview on 04/23/2026 at 3:22 PM, the Administrator stated they would have expected Registered Nurse #6 to have logged out of the electronic medical record and lock the cart. Anyone could have accessed medications in that cart. Accidents could happen. 10 New York Codes, Rules, and Regulations 415.18 (e)(4)

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interviews and record review conducted during the survey, the facility failed to ensure each resident received food that accommodated resident allergies, intolerances, and preferences for one (1) (Resident #164) of one (1) resident reviewed. Specifically, Resident #164 received pork against their religious food preference. The findings include: The facility policy titled Accommodating Cultural Food Preferences revised 05/24/2019 documented the cultural or religious food preferences of residents will be accommodated whenever necessary by the dining services staff, and cultural preferences will be respected and accommodated upon request. The facility policy Assessment of Needs - Dietary revised 07/22/2025, documented each resident will have an assessment of dietary and nutritional needs completed by a Registered Dietitian or Diet Technician. The assessment was done for the following reasons which included but not limited to: record and follow the diet requirements specified by the Attending Physician; to fulfill immediately the personal preferences of the resident with regard to food likes and dislikes, and to address dietary requirements related to food allergies Resident #164 had diagnoses including syncope (fainting) and collapse, unspecified severe protein-calorie malnutrition, and prediabetes. The Minimum Data Set (a resident assessment tool), revised 04/22/2026, documented the resident was cognitively intact and understands and was understood by others. Resident #164 required setup or clean-up assistance with eating. The comprehensive care plan last revised on 04/21/2026 documented Resident #164 had an alteration/potential for alteration in nutrition. Interventions initiated on 04/14/2026 included determining the resident's dietary preferences and offering substitutes as needed. Resident #164 had the following diet ordered: regular, no pork, regular texture, and thin liquids. The Kardex (a guide used by staff to provide care) dated 04/17/2026, documented Resident #164 had the following diet ordered: regular, no pork, regular texture, and thin liquids. The Progress Notes, dated 04/13/2026, documented the resident avoided pork due to religion and pork was added as a dislike in the contracted menu system. During an observation on 04/17/2026 at 8:51 AM, Resident #164 had a breakfast meal tray resting on their tray table, with a covered plate and meal ticket that documented the following information: Resident #164's name, Regular Diet, Regular Texture, Set Up Assistance, Allergy to Shellfish, Thin Liquid, Hall 1 Eating Location, Dislikes: No Pork, Butter, One Half (1/2) Cup Yogurt, Two (2) Banana Chocolate Pancakes, One Half Cup (1/2) Scrambled Egg, Apple Juice Eight (8) Ounces (Thin), and Cranberry Juice Eight (8) Ounces (Thin). Once the cloche was removed, further observation revealed the pancakes were broken apart in a haphazard manor on the plate. During an interview at the time of the observation, Resident #164 stated their first breakfast tray came with bacon and they asked staff to swap it. They received a second breakfast tray, but the pancakes appeared unappetizing; therefore, they did not touch anything on the second breakfast tray. During an interview on 04/17/2026 at 10:39 AM, Certified Nurses' Aide #20 stated they went back to the kitchen to grab another breakfast tray for Resident #164 because the resident informed them there was pork on their first tray. Resident 164's preferences should have been on their meal ticket as there were no religious preferences on the resident's care plan. Certified Nurses' Aide #20 further stated it was important to honor residents' preferences to respect their rights During an interview on 04/17/2026 at 11:10 AM, the Food Service Director stated meal trays were made by dietary staff in the kitchen. The Food Service Director stated dietary staff received a numeric breakdown of what types of trays needed to be made for each meal service, including resident preferences, without the specific resident identified in the breakdown. The Food Service Director further stated nursing staff then read off the individual meal tickets to dietary staff when they obtained the meal trays from the kitchen to be delivered to each unit. The Food Service Director continued to state that dietary staff did not reference individual meal tickets when making the meal trays, and it was the responsibility of nursing staff to obtain the appropriate meal tray for each resident. During an interview on 04/22/2026 at 3:05 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, Registered Dietician #1 stated the facility used a menu planning software system which allowed them to add residents' preferences. Registered Dietitian #1 stated they performed an initial screen for each resident based on nutritional guidelines, discharge and provider summaries, and resident preferences. Registered Dietitian #1 stated meal tickets were based on the criteria and were printed out by the Food Service Director who then delivered the meal tickets to each unit for nursing staff. Additionally, Registered Dietician #1 stated they performed the initial screen for Resident #164 and were aware of the resident's religious preference of no pork. Furthermore, Registered Dietician #1 stated religious preferences were sacred and honoring residents' religious preferences were part of resident rights and resident choice. 10 New York Codes, Rules, and Regulations (NYCRR) 415.14(d)(3)(4)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the survey, the facility failed to ensure they established and maintained 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 two (2) (Resident #8 and Resident #70) of three (3) residents reviewed for Infection Prevention and Control. Specifically, staff failed to maintain enhanced barrier precautions (interventions designed to reduced transmission of multi-drug-resistant organisms (MDRO) including gown and glove use during high contact resident care activities) and wear the appropriate personal protective equipment while providing hands on care to Resident #8 who had pressure ulcers and an indwelling catheter (tube inserted into the bladder to drain urine) and when providing wound care to Resident #70 who had pressure ulcers.The findings include:The facility policy titled Transmission Based Precaution Levels (Type of Infectious Condition Techniques and Documentation) last revised 06/06/2024 documented enhanced barrier precautions involved gown and glove use during high-contact resident care activities for residents known to be colonized or infected with multidrug resistant organisms as well as those at increased risk of multidrug resistant organism acquisition (e.g., residents with wounds or indwelling medical devices). Gown use was needed in high contact resident care activities including dressing, bathing, transferring, providing hygiene, device care and/or wound care to protect skin and prevent soiling of clothing and to reduce the opportunity for transmission of pathogens.Review of the Enhanced Barrier Precaution signage (a sign used by the facility that was posted above a residents bed to indicate they required enhanced barrier precautions) documented that providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting, device care or use; central line, urinary catheter, feeding tube, tracheostomy, and wound care (any skin opening requiring a dressing).1a. Resident #8 had diagnoses including severe sepsis with septic shock (life threatening organ dysfunction caused by a dysregulated response to infection), necrotizing fasciitis (rare, rapidly spreading, and life-threatening bacterial infection that destroys skin fat and muscle tissue), and obstructive and reflux uropathy (obstruction in urinary tract). The Minimum Data Set (a resident assessment tool) dated 04/08/2026 documented Resident #8 was cognitively intact, had an indwelling catheter, had two (2) unhealed pressure ulcers Stage four (4) (severe, full thickness wound extending to exposed muscles, tendon, or bone, often with extensive tunneling or undermining), and two unhealed pressure ulcers Unstageable (full thickness wound where the true depth cannot be determined because it is covered by slough (yellow, tan, gray, green, or brown-soft, devitalized tissue) or eschar (tan, brown, or black-thick, dry dead tissue).The comprehensive care plan dated 03/04/2026 documented Resident #8 had a Stage 4 pressure ulcer to their sacrum, unstageable pressure ulcer to the right heel, unstageable pressure ulcer to left lateral ankle, and Stage 4 pressure ulcer to left heel. Resident #8 was at risk for infection related to pressure ulcers and the indwelling catheter. Interventions included enhanced barrier precautions.The Kardex Report (a guide used by staff to provide care) dated 04/20/2026 documented Resident #8 required moderate assist of one staff member for bed mobility, substantial assistance of one person for transferring from bed-to-chair using a sit to stand lift and was on enhanced barrier precautions.During an observation and interview on 04/15/2026 at 11:49 AM, Resident #8 was sitting up in bed, with a family member present. During the interview, Certified Nurse Aide #19 knocked on the door, wearing gloves and a mask entered with the sit to stand lift and stated they were going to get Resident #8 ready and out of bed; surveyors exited room with the family member. At 11:59 AM, Certified Nurse Aide #19 opened the door and grabbed the wheelchair that was outside of the door, only wearing gloves and a mask. Certified Nurse Aide #19 set the sit to stand up in front of Resident #8, hooked the sling up to the lift and transferred Resident #8 into their wheelchair in their room, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unhooked Resident #8 and removed the sit to stand from the resident and put into the hallway.During an interview on 04/15/2026 at 12:14 PM, Certified Nurse Aide #19 stated when providing care to a resident on enhanced barrier precautions, staff were supposed to wear a gown, gloves, and a mask. There would typically be signage posted outside of the room letting staff know they were supposed to wear the protective equipment. Certified Nurse Aide #19 stated they did not see the sign posted for Resident #8 because it was above their bed, and they were used to it being outside of the room. Certified Nurse Aide #19 stated they should have worn a gown when providing care and transferring Resident #8 and would have if they had noticed the sign. Further stated it was important because bacteria could be passed along, and it was an infection control issue.During an interview on 04/17/2026 at 8:59 AM, Licensed Practical Nurse #8 Unit Manager Unit 1 (in training) stated Resident #8 was on enhanced barrier precautions because they had a sacral wound that was big and deep. It was previously treated with a wound vac (continuous or intermittent suction to promote healing in chronic wounds) but the treatment was changed to a wet to dry dressing recently. Resident #8 had breakdown on their right heel and ankle and had an indwelling catheter in place. Licensed Practical Nurse #8 stated they would have expected staff to wear all personal protective equipment when providing care, including gowns, gloves, and mask if needed. It was important to avoid transmission of any germs. Additionally, Licensed Practical Nurse #8 stated they were not sure why the signs were not outside of the rooms and would inquire about that. 1b. Resident #70 was admitted with diagnoses including type two (2) diabetes, dementia with agitation, and congestive heart failure. The Minimum Data Set, dated [DATE] documented the resident was moderately cognitively impaired, sometimes understood, and sometimes understands. Resident #70 was at risk for pressure ulcers, had one (1) unhealed pressure ulcer Stage 3 (III) (characterized by full thickness tissue loss, visible subcutaneous fat, but no visible muscle, tendon, or bone).The comprehensive care plan dated 02/25/2026 documented Resident #70 had an alteration in skin integrity related to Stage 3 (III) pressure ulcer to right heel, unstageable pressure ulcer to left heel with an intervention to apply treatments as ordered. Resident #70 was at risk for infection related to wounds with an intervention for enhanced barrier precautions. The Kardex Report dated 04/15/2026 documented Resident #8 was totally dependent on staff for lower body dressing, putting on and taking off footwear and was on enhanced barrier precautions.During an observation and interview on 04/17/2026 at 2:14 PM, Licensed Practical Nurse #8 Unit Manager entered the room and pulled the curtain, had treatment supplies lined up on barrier on side of bed; previous treatments already removed from Resident #70's bilateral heels. Licensed Practical Nurse #8 washed their hands, applied gloves, then painted betadine onto Resident #70s right heels large, black, eschar cap, applied abdominal pad then wrapped the heel with kerlix and secured with tape. Licensed Practical Nurse #8 removed their gloves, washed their hands, then applied new gloves. They cleansed Resident #70's left heel, which had a malodorous odor, with Dakins (antiseptic) solution; the gauze used to clean left heel had large amount of dark brown/black drainage. Licensed Practical Nurse #8 stated there was a moderate (large) amount of drainage on the previous treatment when they removed it as well; they applied wet gauze with antiseptic solution then abdominal pad and wrapped the left heel with kerlix and secured with tape. Licensed Practical Nurse #8 stated, I just realized I forgot to put my gown on prior to providing wound care, I should have had one on because I was dealing with bodily fluids, and it was important for infection control.During an interview on 04/22/2026 at 12:57 PM, Assistant Director of Nursing/Infection Preventionist stated they expected staff to wear gowns, gloves, and masks (if needed) during any hands-on resident care, including transferring and wound care for residents on enhanced barrier precautions. They stated it was important for infection control purposes. The Assistant Director of Nursing stated the precaution signage placement was implemented by the previous Director of Nursing; staff had been trained to look above the bed; new orients were trained in general orientation. During an interview on 04/23/2026 at 12:57 PM, the interim Director of Nursing stated they expected staff to use the appropriate personal protective equipment for the task they (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were completing. If providing hands on care staff should be wearing a gown and gloves; there was a risk for spreading unwanted organisms. They would have expected Certified Nurse Aide #19 to have worn a gown when providing care to Resident #8 and would have expected Licensed Practical Nurse #8 to have worn a gown when providing wound care to Resident #70 as these residents were on enhanced barrier precautions.10 New York Codes Rules Regulations 415.19(a)(2)(b)(4)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interviews and record review conducted during the survey completed the facility failed to ensure certified nurse aides were provided the required hours of training and/or annual in-services to ensure safe delivery of care for two (2) (Certified Nurse Aides #2 and #9) of five (5) reviewed. Specifically, Certified Nurse Aides #2 and #9 did not receive 12 hours of nurse aide in-services and education in 2025.The findings include:The policy and procedure titled In-Service Attendance Program dated 07/19/2023 documented administrators were responsible for ensuring all employees and contractors attend annual mandatory training. Announcements for the availability of online and instructor-led training were sent via email, electronic medical record and employee bulletin boards. At the time of the annual job performance review of a staff member, the evaluating manager will take into consideration as to whether or not the staff member was in compliance with mandatory in-service attendance.Review of the Job Description titled Educator dated 07/2023 documented the Educator was responsible to schedule and present training programs to ensure that Nursing Assistants complete six (6) hours of in-service education every six (6) months and oversees tracking of in-service education hours.Review of the learning management system transcripts printed on 04/22/2026 documented Certified Nurse Aide #2 completed five (5) hours and 12 minutes of nurse aide in-services and education. Certified Nurse Aide #9 completed three (3) hours and 24 minutes of nurse aide in-services and education. During an interview on 04/22/2026 at 9:45 AM, the interim Director of Nursing stated they were hired as an Educator for the facility in January 2026. They stated their responsibilities included putting together certified nurse aide and nurse initial training packets for orientation and completing in-services as needed. They stated they just recently got access into the training database in the learning management system to monitor certified nurse aide training. They stated they would have done more as the staff educator but was asked to fill in as the interim Director of Nursing approximately five (5) weeks ago.During a telephone interview on 04/23/2026 at 8:55 AM, Certified Nurse Aide #2 stated they have worked for the facility for three (3) years, and they were aware they were supposed to complete 12 hours of in-service and education a year on things like abuse, infection control and aging. They stated there was someone at the facility who used to remind them if they did not have enough hours of training completed for the year but could not remember who that was.During a telephone interview on 04/23/2026 at 10:08 AM, Certified Nurse Aide #9 stated they had worked for the facility since 2009, and they were not aware how many hours of in-service and training were required a year. They stated that usually the staff educator would let them know if they needed more hours and when trainings were available on the learning management system, but there was not a steady educator at the facility. Certified Nurse Aide #9 stated the learning management system transcript documenting about 3.5 hours of in-service and education sounded correct. They stated if a staff member asked for help with something, someone at the facility would help them and provide education then. Otherwise, education and in-services were not offered consistently.During a telephone interview on 04/23/2026 at 10:26 AM, Educator #1 stated certified nurse aides in-servicing and education was primarily completed in the learning management system. They stated they would have to pull a tracking report from the learning management system to know if the certified nurse aides completed 12 hours of in-service and education. Educator #1 left the position as Educator in November of 2025 and were unable to remember when the last time was, they ran a report from the learning management system.On 04/23/226 at 11:25 AM, a telephone call was placed, and a voicemail was left for the former Director of Nursing. There was no return telephone call received.During an interview on 04/23/2026 at 12:23 PM, the Administrator stated their expectation was that certified nurse aides completed at least 12 hours of in-service and education a year because that would keep them abreast of what was going on and keep them on the right path. They stated Educator #1 was responsible to ensure certified nurse aides were receiving 12 hours of (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-service and education until they left the position in November of 2025. There was not a staff educator in the facility between November 2025 and when the interim Director of Nursing was hired in January 2026.10 New York Codes, Rules, and Regulations 415.26 (c)(1)(iv)

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F 0882 Level of Harm - Potential for minimal harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interviews and record review conducted during the survey, the facility failed to designate one (1) or more individuals as the Infection Preventionist responsible for the facility's Infection Prevention Control Practices. Specifically, the facility did not have a designated Infection Preventionist qualified with specialized education, training, experience, or certification on a part time or fulltime basis. The findings include: The policy and procedure titled Infection Prevention Control Program dated 11/26/2024 documented the Infection Preventionist will oversee the implementation of the program in collaboration with the administrator and each department head in the facility. The facility will designate one (1) or more individual(s) as the Infection Preventionist(s) who was responsible for the facility's Infection Prevention and Control Program as required. The Infection Preventionist will have primary professional training in nursing, medical technology, microbiology, epidemiology or other related fields; be qualified by education, training, experience or certification; works at least part-time at the facility and has completed specialized training in infection prevention and control. The Assistant Director of Nursing Job Description dated 07/2022 documented the Assistant Director of Nursing serves as Infection Control Preventionist. They were responsible for completion of the required Mandatory Infection Preventionist Training. Review of a signed job offer letter dated 03/04/2026 documented Assistant Director of Nursing #1/Infection Preventionist was expected they would secure their Infection Preventionist certification within 30 days of starting the role of Assistant Director of Nursing. Assistant Director of Nursing #1/Infection Preventionist signed the acceptance on 03/08/2026. During the survey entrance conference on 04/15/2026 at 9:00 AM, the Administrator stated Assistant Director of Nursing #1/Infection Preventionist was the Infection Preventionist. Proof of specialized Infection Preventionist training certification was requested. On 04/15/2026 at 12:30 PM, the Administrator provided a Certificate of Training documenting that the Regional Nurse Consultant completed the nursing home Infection Preventionist training course on 11/20/2024. During an interview on 04/16/2026 at 9:58 AM, the Administrator stated Assistant Director of Nursing #1/Infection Preventionist was the Infection Preventionist for the facility and they did not have a certification for the training. They stated the Regional Nurse Consultant oversees the facility and comes into the building. The Administrator stated the Chief Nursing Officer for the Assisted Living Facility helps as well. On 04/16/2026 at 10:02 AM, the Administrator provided a Certificate of Training documenting the Chief Nursing Officer for the Assisted Living Facility completed the nursing home Infection Preventionist training on 01/28/2024. During a telephone interview on 04/17/2026 at 10:56 AM, the Regional Nurse Consultant stated they were focused at another facility, but they assisted the Assistant Director of Nursing #1/Infection Preventionist with questions. The Regional Nurse Consultant stated they were not routinely at the facility but were there maybe once a week. During an interview on 04/17/2026 at 2:17 PM, the Chief Nursing Officer for the Assisted Living Facility stated they were not employed part time or full time at the facility; they worked for the Assisted Living Facility. They stated they assisted the Assistant Director of Nursing #1/Infection Preventionist, but they were not acting as the Infection Preventionist for the facility. On 04/20/2026, the facility provided a Certificate of Training documenting the Assistant Director of Nursing #1/Infection Preventionist completed the nursing home Infection Preventionist training on 04/20/2026. Review of the Train Transcript provided by the facility on 04/22/2026, documented the Assistant Director of Nursing #1/Infection Preventionist completed 92% of the Infection Preventionist training modules between 04/15/2026 and 04/20/2026 with 63% of the training modules being completed on 04/20/2026. During an interview on 04/22/2026 at 12:57 PM, Assistant Director of Nursing #1/Infection Preventionist stated when the Administrator offered the position to them, they were aware they needed to complete the Infection Preventionist training. They stated they completed all the training within the 30 days that the Administrator had given them, but they have not taken the (continued on next page)

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	04/23/2026

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 0882 Level of Harm - Potential for minimal harm Residents Affected - Many	test yet because they wanted to study for it. They stated that they took the test on 04/20/2026 and received the certification of completion. They stated they should have completed the test sooner to show that they had knowledge of infection control. During an interview on 04/23/2026 at 12:23 PM, the Administrator stated Assistant Director of Nursing #1/Infection Preventionist was chosen and assigned the job as infection prevention because it was something they could do. They stated that they gave them 30 days to complete the training, and it should have been completed within that time frame because that was a part of their job. 10 New York Codes, Rules, and Regulations 415.19

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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 0607 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review during the Standard survey completed on 04/23/2026, the facility failed to implement written policies and procedures for screening employees that would prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Specifically, three (3) employees (Certified Nursing Assistant #12, Activity Leader #1, and Housekeeping Aide #1) of 11 employees that were subject to the New York State Nurse Aide Registry Verification, were not reviewed through the New York State Nurse Aide Registry prior to their employment as required. The findings include:Review of the policy and procedure titled Abuse Prevention, Identification, Investigation, Protection and Reporting ADHCP, ALF, SNF last modified 04/30/2024 documented, the facility will provide protection for the health, welfare and rights of each resident residing in the facility. The administrator of the facility is responsible for the development and implementation of written policies and procedures that prohibit and prevent abuse, mistreatment, neglect, exploitation of residents, and misappropriation of resident property.Screening Policy: Prior to hire, all prospective staff will be screened for a history of abuse, mistreatment, neglect, exploitation, or misappropriation of resident property per state and federal regulations.Procedure:1. The Human Resources Coordinator will attempt to obtain information from previous employers and/or current employers and request references. Background checks will be completed, and appropriate licensing boards and registries will be checked per federal and state requirements. The employment history, information from former employers, whether favorable or unfavorable; and/or documentation of status and any disciplinary actions from licensing or registration boards and other registries will be considered in the screening process.1a. During an interview on 04/21/026 at 9:43 AM the Human Resources Manager stated Certified Nursing Assistant #12 was hired on 02/25/2026. The New York State Nurse Aide Registry Verification report for Certified Nursing Assistant #12 was dated 03/03/2026, and that Certified Nursing Assistant #12 worked in the facility on 03/02/2026.Review of the employee file of Certified Nursing Assistant #12 revealed the employee was hired on 02/25/2026 to be a Certified Nursing Assistant. Further review of the employee's file revealed it contained a New York State Nurse Aide Registry Verification report for the employee that was dated 03/03/2026.Review of Certified Nursing Assistant #12 ?s electronic timecards revealed they worked in the facility on 03/02/2026 from 2:30 PM until 10:00 PM.1b. During an interview on 04/21/026 at 9:48 AM the Human Resources Manager stated Activity Leader #1 was hired on 03/25/2026. The New York State Nurse Aide Registry Verification report for Activity Leader #1 was dated 04/15/2026, and that the employee worked in the facility as an Activity Leader prior to the completion of their New York State Nurse Aide Registry Verification report.Review of the employee file for Activity Leader #1 revealed the employee was hired on 03/25/2026 to be an Activity Leader. Further review of the employee's file revealed it contained a New York State Nurse Aide Registry Verification report for the employee that was dated 04/15/2026.Review of Activity Leader #1 ?s electronic timecards revealed they worked in the facility on:-03/27/2026 from 9:00 AM until 5:00 PM.-03/28/2026 from 9:00 AM until 5:00 PM.-04/01/2026 from 1:00 PM until 7:00 PM.-04/03/2026 from 4:00 PM until 8:00 PM.-04/06/2026 from 2:00 PM until 8:00 PM.-04/08/2026 from 2:00 PM until 8:00 PM.-04/09/2026 from 4:00 PM until 8:00 PM.-04/10/2026 from 4:00 PM until 8:00 PM.-04/14/2026 from 4:00 PM until 8:00 PM.1c. During an interview on 04/21/026 at 9:57 AM the Human Resources Manager stated Housekeeping Aide #1 was hired on 02/25/2026, the New York State Nurse Aide Registry Verification report for Housekeeping Aide #1 was dated 03/03/2026, and that the employee worked in the facility as a Housekeeping Aide prior to the completion of their New York State Nurse Aide Registry Verification report.Review of the employee file for Housekeeping Aide #1 revealed the employee was hired on 02/25/2026 to be a Housekeeping Aide. Further review of the employee's file revealed it contained a New York State Nurse Aide Registry Verification report for the employee that was dated 03/03/2026.Review of Housekeeping Aide #1's electronic timecards revealed they worked in the (continued on next page)

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Some	facility on:-02/26/2026 from 7:00 AM until 3:02 PM.-02/27/2026 from 6:59 AM until 2:51 PM.-03/02/2026 from 6:56 AM until 2:55 PM. 10 New York Codes, Rules, and Regulations (NYCRR)415.4(b)

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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 0836 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the Standard survey completed on 04/23/26, the facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes. Specifically, the facility was not in compliance with Section 915 of the 2025 Fire Code of New York State, which requires that an interior space in a Nursing Home that contains a direct carbon monoxide source shall be provided with carbon monoxide detection if there are communicating openings between the spaces, and on-going preventative maintenance of carbon monoxide detectors. This affected four (4) (Unit 1, Unit 2, Unit 3, and Unit 4) of four (4) resident units and one (1) of one (1) Service corridor on two (2) (First floor and Second floor) of two (2) resident use floors. The findings include but are not limited to: According to the 2025 Fire Code of New York State, new and existing buildings shall be provided with carbon monoxide (CO) detection and notification in accordance with Sections 915.2 through 915.5. Additionally, the 2025 Fire Code of New York State stated that an interior space in a Nursing Home that contains a direct carbon monoxide source shall be provided with carbon monoxide detection if there are communicating openings between the spaces, and on-going preventative maintenance of carbon monoxide detectors. The 2025 Fire Code of New York State also stated carbon monoxide alarms and carbon monoxide detection systems shall be maintained in accordance with National Fire Protection Association (NFPA) 72, National Fire Alarm and Signaling Code, and the manufacturer's instructions. Observations on 04/17/2026 between 1:35 PM and 2:10 PM and on 04/20/2026 at 8:51AM and 8:52AM revealed two (2) different models (Model A and Model B)of plug in style, battery backup carbon monoxide alarms, and one (1) battery operated model (Model C) of carbon monoxide alarms were installed on the First and Second floors of the facility. Further observations during these times revealed resident sleeping rooms were located on the First floor and Second floor and fuel burning appliances were located on the First floor. During an interview on 04/20/26 at 2:21 PM the Maintenance Supervisor stated there were two (2) different models of the plug in style with battery backup carbon monoxide alarms and one (1) model of battery-operated carbon monoxide alarms installed in the facility. The Maintenance Supervisor further stated the carbon monoxide detectors were tested monthly by the Maintenance staff and that the Maintenance staff were not cleaning the carbon monoxide alarms. Review of CO Detectors PM Checklists dated 01/31/2025 through 03/25/2026 revealed the facility's carbon monoxide alarms were tested monthly. 1a. Observation on the First floor on 04/17/2026 at 1:37 PM revealed a Model A plug in style with battery backup carbon monoxide alarm was plugged into a duplex electrical outlet in the corridor between Resident rooms [ROOM NUMBERS] on Unit 1. Further observation revealed the top of the cover of the carbon monoxide alarm was covered in an approximate one eighth inch layer of dust. 1b. Observation on the Second floor on 04/17/2026 at 2:01 PM revealed a Model A plug in style with battery backup carbon monoxide alarm was plugged into a duplex electrical outlet in the corridor between Resident rooms [ROOM NUMBERS] on Unit 3. Further observation revealed the top of the cover of the carbon monoxide alarm was covered in an approximate one eighth inch layer of dust. 1c. Observation on the Second floor on 04/17/2026 at 2:02 PM revealed a Model A plug in style with battery backup carbon monoxide alarm was plugged into a duplex electrical outlet in the corridor between Resident rooms [ROOM NUMBERS] on Unit 3. Further observation revealed the top of the cover of the carbon monoxide alarm was covered in an approximate one eighth inch layer of dust. 1d. Observation on the Second floor on 04/17/2026 at 2:09 PM revealed a Model A plug in style with battery backup carbon monoxide alarm was plugged into a duplex electrical outlet in the corridor between Resident rooms [ROOM NUMBERS] on Unit 4. Further observation revealed the top of the cover of the carbon monoxide alarm was covered in an approximate one eighth inch layer of dust. (continued on next page)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the Carbon Monoxide Detector Instruction Guide for the (Model A) plug in style with battery backup carbon monoxide alarms revealed: Cleaning: Clean the detector regularly by vacuuming the outside of the unit with a soft brush attachment. Do not use solvents or sprays directly into the unit. 2a. Observation on the First floor on 04/17/2026 at 1:40 PM revealed a Model B plug in style with battery backup carbon monoxide alarm was plugged into a duplex electrical outlet in the corridor between Resident room [ROOM NUMBER] and the Bathing Suite near Resident room [ROOM NUMBER] on Unit 2. Further observation revealed the top of the cover of the carbon monoxide alarm was covered in an approximate one eighth inch layer of dust. 2b. Observation on the First floor on 04/17/2026 at 1:43 PM revealed a Model B plug in style with battery backup carbon monoxide alarm was plugged into a duplex electrical outlet in the corridor between Resident rooms [ROOM NUMBERS] on Unit 2. Further observation revealed the top of the cover of the carbon monoxide alarm was covered in an approximate one eighth inch layer of dust. Review of the Carbon Monoxide Detector User's Manual for the (Model B) plug in style with battery backup carbon monoxide alarms revealed: To Keep the Carbon Monoxide Alarm in good working order: Vacuum the Carbon Monoxide Alarm cover once a month, using the soft brush attachment. Never use water, cleaners, or solvents, since these may damage the unit. Test the Carbon Monoxide Alarm again after vacuuming. 3a. Observation on the First floor in the Service corridor on 04/20/2026 at 8:52 AM revealed three (3) Model C battery operated carbon monoxide alarms were installed on walls inside the Kitchen. Review of the Carbon Monoxide Alarm User Guide for the (Model C) battery operated carbon monoxide alarms revealed: Maintenance Tips. To keep your alarm in good working order, you must follow these steps: Test the alarm once a week by pressing the Test/Reset button. Vacuum the alarm cover once a month to remove accumulated dust. 42 CFR 483.70(b)10 New York Codes, Rules, and Regulations (NYCRR): 415.29(a)(2), 711.2(a)(1)2025 Fire Code of New York State, Section 915: 915.1,915.2, 915.2.2, 915.5