STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335020	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hebrew Home for the Aged at Riverdale	5901 Palisade Avenue Riverdale, NY 10471

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:3Number of residents cited:1 Based on observation, record review, and interviews, the facility failed to ensure each resident's right to receive written notices, including the reason for the changes, before the resident's room in the facility was changed. This was identified for one (1) of three (3) resident (Resident #368) reviewed for Choices. Specifically, on 03/18/2026 Resident #368 was relocated to a new room on the same floor without receiving a written notice before the room was changed.The findings include:The policy titled Change of Room or Roommate dated 03/2009, last revised 06/2025, documented that facility conduct room changes when considered to be necessary by the facility and/or when requested by the resident or resident representatives. The policy also documented that the notice of a change in room will be provided in writing, in a language and manner the resident and representatives understand and will include the reason(s) why the move or change is required. Resident #368 was admitted with diagnoses that included Septic shock, Heart failure, and Hypotension.The admission Minimum Data Set assessment dated [DATE] documented Resident #368 was cognitively intact and participated in the assessment and goal setting.On 03/19/2026 at 11:32 AM, Resident #368 and family members were interviewed and stated that they were notified about room change for another resident who needs to use shower room but denied receiving a written notice in advance. Resident #368 also stated that the facility did not give them an option to refuse the room change and they wanted to go back to the previous room. On 03/23/2026 at 9:37 AM, Resident #368 was interviewed and stated that they were still not satisfied with room changes, and no one had asked them if they were ok with the room change. Resident #368 also stated that facility informed them about the room change in the morning then changed the room in the afternoon on that same day.The Social Services progress note dated 03/18/2026 documented Resident #368 had a room change on 03/18/2026.The Social Services progress note dated 03/18/2026 documented they spoke to resident and family members that resident needed to change rooms for a resident with a medical necessity and family and resident receptive.There was no evidence that a written notice of room change was provided to Resident #368 or their representative. On 03/24/2026 at 11:30 AM, the Director of Social Work provided the State Surveyor with a notice titled New Room/Roommate Notification dated 03/18/2026 which was addressed to Resident #368 and stated they will be receiving a new room on 03/18/2026 and the reason for room change was medical need. On 03/24/2026 at 11:47 AM, Resident #368 was interviewed and stated that they had not received a written notice regarding the room change before the change occurred. The State Surveyor showed Resident #368 the copy of the notification which the Director of Social Work provided them and asked if Resident #368 had received it before the room change. Resident #368 stated that they had not seen that form before and repeated that they did not receive any written notification before the room was changed.On 03/24/2026 at 12:30 PM, the Director of Social Work was interviewed and stated the Social Worker involved was scheduled off and was not available for interview. The Director of Social Work stated room changes were conducted when residents requested or facility needed for medical reasons such as isolation. The Director of Social Work also stated that social workers were (continued on next page)

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for notifying resident and resident's representatives of the room changes. The Director of Social Work further stated that they had communication with resident and family members, informed them of necessary room changes on the same day. The Director of Social Work stated that they provided a written notice of room changes to the resident and kept one copy in the social work's office. The Director of Social Work stated that they do not request residents and/or their representatives' signatures for the receipt of notification of room changes. 10 New York Codes, Rules, and Regulations 415.5(e)(2)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interviews, the facility failed to ensure residents were afforded the right to formulate the advance directive of their choice. This was evident for one (1) of three (3) residents (Resident #106) reviewed for Advance Directives out of a sample of 38 residents. Specifically, the Physician Order in the electronic medical record documented Resident #106's code status as do not intubate while the Medical Orders for Life-Sustaining Treatment form did not match the physician's order and documented do not attempt resuscitation and do not intubate instead. The findings include:The policy and procedure titled Advance Directives/Medical Orders for Life-Sustaining Treatment Forms last revised in 03/2026 stated it is the facility's obligation to ensure that those residents, their Health Care Proxy and/or surrogates who have requested advance directives and whose request meet the criteria under the state law shall have these requests honored by a physician's order in the resident's medical chart. The policy also stated it is also the facility's responsibility to ensure that this order is communicated, kept current, periodically reviewed, and verified, and is carried out when available.Resident #106 had diagnoses which included Non-Alzheimer's dementia (memory loss and thinking problems), Parkinson's disease (brain loses the ability to control movement), and hypertension (high blood pressure).The Quarterly Minimum Data Set Assessment (a resident assessment tool) dated 01/30/2026, documented Resident #106 had intact cognition.The Medical Orders for Life-Sustaining Treatment form dated 05/23/2017 and last reviewed on 01/30/2026 documented options which included do not resuscitate and do not intubate.A physician's order dated 01/21/2026 documented do not intubate.A medical progress note dated 02/01/2026 (date of service 01/30/2026) documented Resident #14's advance directives for do not resuscitate and do not intubate have been signed and order initiated.A review of the physician orders, hard chart, and electronic medical record on 03/19/2026 revealed no physician orders for Resident #106 which documented Resident #106's code status as do not attempt resuscitation.On 03/24/2026 at 12:09 PM, Social Worker #1 was interviewed and stated advance directives are reviewed quarterly during care plan meetings. Social Worker #1 also stated they recently asked Resident #106 about their advance directives, and they deferred to their next of kin. Social Worker #1 further stated they called Resident #106's next of kin to discuss Resident #106's advance directives on 03/19/2026, and the next of kin confirmed Resident #106's code status as do not resuscitate.On 03/24/2026 at 12:30 PM, the [NAME] President of Social Services was interviewed and stated social workers review advance directives quarterly and they were unable to provide an explanation for why Resident #106 did not have an order for do not resuscitate among their physician orders.On 03/24/2026 at 4:45 PM, the [NAME] President of Nursing was interviewed and stated when the Medical Orders for Life-Sustaining Treatment is reviewed by the physician, the physician orders should also be reviewed to ensure they match. On 03/25/2026 at 2:40 PM, Physician #1 was interviewed and stated they are not sure why the do not resuscitate order was not in place in Resident #106's physician orders. Physician #1 also stated they did not cross check the orders on the Medical Orders for Life-Sustaining Treatment form with the physician orders in Resident #106's electronic medical record because they assumed both the Medical Orders for Life-Sustaining Treatment and physician orders matched since there were no changes made at that time. 10 New York Codes, Rules, and Regulations 415.3(e)(1)(ii)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews, the facility failed to ensure that a comprehensive person-centered care plan was developed and implemented for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs. This was evident for one (1) of six (6) residents (Resident #14) investigated for Activities of Daily Living out of 38 total sampled residents. Specifically, a care plan to address hospice care was not developed for Resident #14. The findings are:The facility policy and procedure titled Person-Centered Care Planning revised on 02/02/2026 stated the comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Resident #14 had diagnoses of diabetes mellitus (too much sugar in the blood), hypertension (high blood pressure), and peripheral vascular disease (blood vessels outside the heart and brain become narrowed and blocked).The Quarterly Minimum Data Set (a resident assessment tool) dated 03/04/2026 documented Resident #14 had severely impaired cognition.A physician's order dated 03/09/2026 documented hospice care on 03/08/2026.A Calvary Hospital Hospice Social Worker note dated 03/08/2026 documented that Resident #14 was admitted to hospice today.A review of Resident #14's comprehensive care plans had no documented evidence that a care plan to address hospice care was developed. On 03/24/2026 at 12:15 PM, Social Worker #1 was interviewed and stated the social service department is responsible for creating a care plan to address that Resident #14 is receiving hospice care. Social Worker #1 was unable to provide an explanation for why Resident #14 did not have a care plan in place for hospice care. On 03/24/2026 at 12:24 PM, the [NAME] President of Social Services was interviewed and stated there is not a specific care plan for hospice in the electronic medical record system the facility recently implemented. The [NAME] President of Social Services also stated they usually try to create a hospice care plan or update the advance directives care plan as soon as a resident is placed on hospice.10 New York Codes, Rules, and Regulations 415.11(c)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interviews, the facility failed to ensure infection control practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. This was evident for one (1) of five (5) nurses observed during medication administration. Specifically, Registered Nurse #5 failed to sanitize the blood pressure cuff in between residents.The findings include:The facility's policy titled Medline Vital Signs Monitoring Device dated 07/2021, last reviewed date of 03/2025 stated Nurse and Certified Nursing Assistant cleans the machine with germicidal alcohol wipes and washes hands before resident's care. The policy further stated in procedure #12 (page 3 of 4), Nurse and Certified Nursing Assistant will wipe the blood pressure cuff after each use. On 03/24/2026 at 9:17 AM, during medication administration observation on the 6th Floor Registered Nurse #5 observed taking Resident #325's blood pressure without sanitizing the blood pressure cuff before and after using.On 03/24/2026 at 9:27 AM, Registered Nurse #5 was observed applying the same blood pressure cuff to Resident #148. Registered Nurse #5 failed to sanitize the blood pressure cuff before and between each resident. On 03/24/2026 at 10:55 AM Registered Nurse #5 was interviewed and stated that they were supposed to clean and sanitize the blood pressure cuff with sanitizing wipes between each resident to prevent infection but stated that they were nervous and forgot to do it. On 03/24/2026 at 11:02 AM, Registered Nurse Supervisor #1 was interviewed and stated that they were responsible for supervising Registered Nurse #5 to ensure that they properly sanitize the reusable equipment. Registered Nurse Supervisor #1 also stated that the blood pressure cuff must be cleaned in between residents, and the staff should use the purple top sanitizing wipes. Registered Nurse Supervisor #1 further stated that they provided in-services and competency to ensure staff are sanitizing the reusable equipment properly.On 03/24/2026 at 3:42 PM, the Nursing Compliance Manager #1 was interviewed and stated that blood pressure cuff must be sanitized with purple top wipes before and after using it, between resident to resident. 10 New York Codes, Rules, and Regulations 415.19(a)(1-3)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 2Number of residents cited: 2 Based on observation, record review and staff interviews, the facility failed to ensure that the residents and their representatives were provided with a summary of the baseline care plan. This was evident for two (2) of two (2) residents (Residents #102 and #368) reviewed for Care Planning out of 38 sampled residents. Specifically, there was no documented evidence that Resident #102 and Resident #368 or their representatives had received a written summary of their baseline care plan.The findings include: The facility policy titled Baseline Care Plan dated 05/05/2017, last revised 02/02/2026 stated that the baseline care plan will be developed within 48 hours of a resident's admission. The policy also stated that a Social Worker is responsible for providing the written summary of the baseline care plan to the residents and representatives. 1.Resident #102 was admitted on [DATE] with diagnoses of right knee arthroplasty (joint replacement surgery), Morbid obesity, and Anxiety.The admission Minimum Data Set assessment (a resident assessment tool) dated 02/08/2026 documented resident was cognitively intact, required Substantial/ Maximal assistance of staff for most Activities of Daily Living. The admission Minimum Data Set assessment also documented Resident#102 and family participated in the assessment and goal setting.On 03/19/2026 at 12:07 PM, Resident #102 was interviewed and stated that they had not been given a written summary of the initial baseline care plan.Review of Resident #102's electronic medical record revealed a baseline care plan, created 02/02/2026, with a lock date of 02/09/2026 which was signed by the facility interdisciplinary team members but was not signed by the resident or their representative.There was no documented evidence that a copy of the baseline care plan was provided to Resident #102 or their Representative.2. Resident #368 was admitted on [DATE] with diagnoses of Septic shock, Heart failure, and Hyperthyroidism.The admission Minimum Data Set assessment dated [DATE] documented Resident #368 was cognitively intact and participated in the assessment and goal setting.On 03/19/2026 at 11:32 AM, Resident #368 was interviewed and stated that they had not been given a written summary of their baseline care plan.Review of Resident #368's electronic medical record revealed a baseline care plan, created 03/10/2026, with a lock date of 03/12/2026, which was signed by the facility interdisciplinary team members but was not signed by the resident or their representative.There was no documented evidence that a copy of the baseline care plan was provided to Resident #368 or their Representative.On 03/24/2026 at 11:55 AM, Registered Nurse Supervisor #3 was interviewed and stated that Nursing and Social Worker completed the baseline care plan in the electronic medical record within 48 hours of admission. Registered Nurse Supervisor #3 also stated that after completion of Baseline care plan, they reviewed it to see if there were any missing items. Registered Nurse Supervisor #3 further stated that nursing staff do not provide a copy of baseline care plan to the residents or their representatives.On 03/24/2026 at 12:30 PM, the Director of Social Work was interviewed and stated that the baseline care plan is completed by nursing and the social worker within 48 hours of admission. The Director of Social Work also stated the social work department was responsible for reviewing and providing the baseline care plan to the residents or their representatives within five (5) days of admission and kept one copy in the social work office. The Director of Social Work further stated they do not document in the progress notes after providing a copy of baseline care plan to the residents or their representatives, and they do not request residents and/or their representatives' sign when they receive a copy of the baseline care plan. 10 New York Codes, Rules and Regulations 415.11(c)(1)