STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335078	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yorktown Rehabilitation & Nursing Center	2300 Catherine Street Cortlandt Manor, NY 10567

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00348017/806183), the facility did not ensure assessments accurately reflected the resident's status for 1 out of 3 residents (Resident #1) reviewed for assessments. Specifically, Resident #1 who was cognitively impaired, had chronic confusion and gait/balance disturbances was not identified as a high risk for falls on admission. Resident #1 had an unwitnessed fall on 06/08/2024 and sustained a laceration to their left eyebrow and a bruise to their left elbow. Review of Resident #1's fall risk assessment dated [DATE] revealed it was not completed, reflecting inaccurate scoring on the assessment tool.The findings are:Resident #1 was admitted with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus and Peripheral Vascular Disease.An admission Minimum Data Set, dated [DATE] documented Resident #1 had severe cognitive impairment. Resident #1 had impairment to their upper extremities on both sides and required a walker or a wheelchair for locomotion. The resident required set up assistance with meals, moderate assistance with toileting, maximal assistance with bed mobility and transfers. Review of a risk for falls care plan initiated 05/06/2024 documented Resident #1 was at a low risk for falls as evident by the scoring tool. Resident #1 had a fall risk score of 6 indicating a low risk for falls. Interventions listed included assist resident with ambulation and transfers utilizing therapy recommendations and determine resident's ability to transfer. Review of a fall risk assessment dated [DATE] documented Resident #1 was alert and oriented x 3 and chairbound. The gait/balance section and remainder of the assessment was not completed, indicating a partial fall risk score was tallied and incorrect. Review of an impaired cognition care plan initiated 05/07/2024 documented Resident #1 had an impaired thought process related to their Brief Interview of Mental Status score assessment. Interventions listed included ask yes/no questions in order to determine the resident's needs, communicate with and the resident/family/caregivers regarding resident's needs and monitor/document/report as needed any changes in cognitive function.Review of Resident #1's admission assessment dated [DATE] documented Resident #1 was chronically confused and had mild cognitive impairment.During a telephone interview on 08/27/2025 at 12:12 PM, the Director of Nursing stated the fall risk assessment, and the admission assessment were completed by Registered Nurse #2. The Director of Nursing stated they reviewed Resident #1's fall assessment and they noticed the assessment was incomplete because the balance/gait section was not completed by Registered Nurse #2. The Director of Nursing stated Resident #1 was not alert and oriented as indicated on the admission assessment by Registered Nurse #2. The Director of Nursing stated Registered Nurse #2 choose the wrong option out of the 3 choices indicated on the form for mental status. If they had performed the assessment, they would have chosen the option for intermittent confusion. With the fall risk assessment, the total tally will reflect the information documented during the assessment. Resident #1's fall risk assessment was incomplete and therefore the score tallied by the system was inaccurate. During a telephone interview on 08/28/2025 at 9:45 AM, Registered Nurse #2 stated they completed Resident #1's admission and fall risk assessments on 05/06/2024. Registered Nurse #2 stated during the admission assessment they asked the resident questions to check their mental capacity, and this is how they determine the resident's cognitive status. Registered Nurse #2 stated they documented Resident #1's mental status based on their answers to questions asked. On the fall risk score evaluation, Registered nurse #2 stated sometimes there are glitches within point click care (the electronic medical record system) and the system will generate a different score. The fall risk score of 6 for Resident #1 was inaccurate as it indicates the resident is a low fall risk. The facility is now using a different version of the fall risk assessment form which is shorter and all information to be gathered are located on the same form to avoid errors such as this. Registered Nurse #2 stated some of the errors encountered with the new system was when a section of the form was not completed, the system does not allow you to return to the uncompleted portion of the form to enter any updates. These omissions then generate inaccurate scores/tallies because of the omissions. The scores/tallies do not reflect the complete assessment.Registered Nurse #2 did not provide an answer as to why they documented Resident #1's cognitive status as alert and oriented x3 on the admission assessment and chronic confusion with mild cognitive impairment on the fall assessment on 05/08/202510 NYCRR 415.11(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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00348017/806183), the facility did not ensure the resident environment remained as free of accident hazards as is possible; and that each resident received adequate supervision to prevent accidents for 1 out of 3 residents (Resident #1) reviewed for safety and supervision. Specifically, Resident #1 who had severe cognitive impairment with impaired thought process was assessed on admission as a low fall risk for fall. Resident #1 was left alone in their room on 6/8/2024. The resident had an unwitnessed fall and sustained a laceration to their left brow and bruising to their left elbow. Resident #1's room was located behind the nurse's station out of view from. Resident #1 had no specific measures in place for monitoring and oversight. The findings are:The facility Accident and Incident Prevention/Fall Risk policy last revised 11/21 documented it id the policy of the facility that safety is everyone's responsibility. Being alert and anticipating hazards can prevent most accidents. The best defense against injury is safety awareness. The facility cannot prevent all fall, but they can identify those at risk and place appropriate interventions to minimize the risk of falling and specifically minimize the risk of injury. Resident #1 admitted to the facility on [DATE] with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus and Peripheral Vascular Disease.An admission Minimum Data Set, dated [DATE] documented Resident #1 had severe cognitive impairment. Resident #1 had impairment to their upper extremities on both sides and required a walker or a wheelchair for locomotion. The resident required set up assistance with meals, moderate assistance with toileting, maximal assistance with bed mobility and transfers. Review of a risk for falls care plan initiated 05/6/2024 documented Resident #1 was at a low risk for falls. Resident #1 was scored at a 6 indicating a low risk for falls. Interventions listed included assist resident with ambulation and transfers utilizing therapy recommendations and determine resident's ability to transfer.Review of an impaired cognition care plan initiated 05/7/2024 documented Resident #1 had an impaired thought process related to their Brief Interview of Mental Status score assessment. Interventions listed included ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding resident's needs and monitor/document/report as needed any changes in cognitive function.Review of Resident #1's admission assessment dated [DATE] documented interventions for safety as the call light will be in reach, the resident would have 1/2 side rails. Resident #1 had an unsteady gait and poor balance.During rounds in the facility Resident #1's room was observed to be behind the nurse's station out of staff view. There was no documented evidence of any supervision or monitoring of Resident #1's safety in place.During an interview on 08/7/2025 at 11:40 AM Licensed Practical Nurse #1 stated the morning of the fall Resident #1 was acting impulsive, but generally they were not impulsive. During an interview on 08/7/2025 at 11: 51 AM Registered Nurse #1 stated Resident #1 was a fall risk, and they were not safe to be left alone in their room.During an interview on 08/7/2025 at 12:45 PM the Director of Nursing stated Resident #1 was safe to be in the room by their self, but the resident was confused and impulsive. The Director of Nursing stated Resident #1's representatives would push them to walk a lot when they were visiting. The Director of Nursing stated the rehabilitation unit had private rooms, so Resident #1 was in a room by themself. The Director of Nursing stated Resident #1's room was moved to a viewed room near the nursing station after their fall, due to the resident getting up from the wheelchair.During an interview on 08/7/2025 at 2:40 PM the Administrator stated their investigation findings revealed that rounding is important.During a telephone interview on 08/27/2025 at 10:17 AM Certified Nurse Aide #1 stated the day of the incident, they were assigned to Resident #1. That was their first time taking care of the resident. The resident was a fall risk, so they were the first resident provided cares to and got them up. Certified Nurse Aide #1 stated they were informed during shift report from other certified nurse aides and Licensed Practical Nurse #1 that Resident #1 was a fall risk. Certified Nurse Aide #1 stated after they finished with Resident #1, they handed them their call bell and their urinal and left the resident in their wheelchair with the wheels locked. Certified Nurse Aide #1 stated they handed out the breakfast trays to the residents on the unit and there was a thirty-to-forty-minute time gap since they had last saw the resident. Certified Nurse Aide #1 stated they heard a commotion and went to Resident #1's room and found the resident on the floor. They wheeled the resident out to the nurses' station after their care and the nurse told them the family does not like it and wheel the resident back into their room. Certified Nurse Aide #1 stated Resident #1's representatives requested Resident #1 not be placed by the nurse's station and to leave them in their room