STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335080	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Hill Center for Rehabilitation & Nursing	65 Ashburton Avenue Yonkers, NY 10701

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 44266 Based on record review and interviews conducted during an abbreviated survey (NY00347152), the facility did not ensure residents were free from abuse neglect/misappropriation of property and exploitation and that non dialysis residents were protected for 1 (Resident #3) of 3 residents reviewed. Specifically, (1) on 7/2/2024 during a discharge planning meeting with the facility social worker, Resident #1 alleged that the dialysis transportation worker withdrew a total amount of $5,900 from their cash app account. The incident was reported to Law enforcement on 7/3/2024. The facility did not ensure the transportation worker did not have access to resdientst who were not on dialysis. The findings are: The Policy and procedure titled Abuse, Neglect, Mistreatment & Exploitation Prevention & Elder Justice Act last reviewed 02/06/24 documented, .It is our policy to ensure that residents are free of verbal, neglect and misappropriation of property Resident #3 had diagnoses including but not limited to Congestive Heart Failure, Cerebral Infraction, and Ataxia following other Cerebrovascular Disease. The Minimum Data Set (MDS, an assessment tool) dated 10/25/24 documented that the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 15/15 associated with intact cognition. Review of the Facility Investigation Summary dated 07/05/24 documented on 07/02/24 Resident #1 reported to Social Worker that there was an employee (Transportation Worker/Dialysis Staff) at the facility who had been taking their money to assist with finding an apartment. Staff inquired about who the staff member was, and Resident #1 showed an application on their phone that revealed $5,900 was sent to the Transportation Worker since 06/05/24. Resident #3 stated the Transportation Worker told them they would be able to get them into an apartment with the money but never complied. Facility Summary documented the money was stolen but did not substantiate or unsubstantiate the allegation. There was no documented evidence that other residents who were transported by the dialysis transportation worker were interviewed. There was no documented written statement from the dialysis transportation worker, the alleged accused. Review of Resident #3's Electronic Medical Record on 12/09/24 revealed there was no abuse care plan initiated to protect the resident from further abuse. (continued on next page)

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 11:01 AM with Resident #1, they stated they had $6500 dollars stolen by the staff member (Transportation Worker/Dialysis Staff). Resident #3 stated they were not sure of the persons title that stole their money, but they were told by the facility that the staff member worked for the dialysis center. Resident #3 stated they were not a dialysis resident and they felt like the staff member scooped them out. Resident #3 stated the staff member came to them and told them they would assist them with finding an apartment and stated they had helped other residents in the past. Resident #1 stated the staff member asked for $75 dollars for an application fee and it just continued from there. Resident #1 stated the staff member was also coming into their room, taking their phone, and sending $500 dollars at a time to themselves. Resident #1 stated they heard the staff member did this to other residents but was unable to name them. Resident #3 stated the police informed them they were investigating but no one had followed up with them. Resident #3 stated they just want their money back as they planned on using that for furniture once discharged from the facility. Resident #3 was asked to show surveyor their cash app application and stated they did not know how to pull up the information. During an interview on 11/20/24 at 11:34 AM, the Director of Nursing stated the transportation worker did not work for the facility, they worked for the Dialysis center that is operated by a different management. The Director of Nursing stated the transportation worker came upstairs to transport resident's downstairs to the dialysis center. The Director of Nursing stated they could not conclude misappropriation for Resident #1 because they did not know what conversation was held between Resident #1 and the transportation worker. The Director of Nursing stated they put psych support in place for Resident #1 and contacted the police department, but the transportation worker is not an employee of the facility. During an interview on 12/09/24 at 2:25 PM, the Administrator stated they ensured all staff were in-serviced on abuse/misappropriation and how to interact with residents following Resident #3's misappropriation. The Administrator stated the transportation worker was also no longer allowed in the building. The Administrator stated they spoke with the director of the dialysis center, and going forth residents will be brought to the elevator by the facility staff to be picked up by the dialysis transportation staff. This will prevent the dialysis staff from entering residents' rooms. The Administrator stated staff have been instructed to have dialysis residents wait by the elevators for pick up. An attempt to contact the transportation worker by phone 11/21/24 at 1:06 PM was unsuccessful. Phone number was no longer in service. 10NYCRR 415.4(b)(1)(i)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 44266 Based on record review and interviews conducted during an abbreviated survey (NY00347152), the facility did not ensure residents rights to be free from abuse/misappropriation of property for 1 (Resident #3) of 3 residents reviewed for abuse. Specifically, on 7/2/24 during a discharge planning meeting with the facility social worker, Resident #3 alleged that the dialysis transportation worker withdrew a total amount of $5,900 from their cash app account. The incident was reported to Law enforcement on 7/3/24; (2) There was no documented evidence that other residents who were transported by the dialysis transportation worker were interviewed after the incident. The Findings are: The policy and procedure titled Abuse, Neglect, Mistreatment & Exploitation Prevention & Elder Justice Act last reviewed 02/06/24 documented, It is our policy to ensure that residents are free of verbal, neglect and misappropriation of property Resident #3 had diagnoses including but not limited to Congestive Heart Failure, Cerebral Infraction, and Ataxia following other Cerebrovascular Disease. The Minimum Data Set (MDS, an assessment tool) dated 10/25/24 documented that the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 15/15 associated with intact cognition. Review of the Facility Investigation Summary dated 07/05/24 documented on 07/02/24 Resident #1 reported to Social Worker that there was an employee (Transportation Worker/Dialysis Staff) at the facility who had been taking their money to assist with finding an apartment. Staff inquired about who the staff member was, and Resident #1 showed an application on their phone that revealed $5,900 was sent to the Transportation Worker since 06/05/24. Resident #3 stated the Transportation Worker told them they would be able to get them into an apartment with the money but never complied. Facility Summary documented the money was stolen but did not substantiate or unsubstantiate the allegation. There was no documented evidence that other residents who were transported by the dialysis transportation worker were interviewed. There was no documented written statement from the dialysis transportation worker, the alleged accused. Review of Resident #3's Electronic Medical Record on 12/09/24 revealed there was no abuse care plan initiated to protect the resident from further abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 11:01 AM with Resident #1, they stated they had $6500 dollars stolen by the staff member (Transportation Worker/Dialysis Staff). Resident #3 stated they were not sure of the persons title that stole their money, but they were told by the facility that the staff member worked for the dialysis center. Resident #3 stated they were not a dialysis resident and they felt like the staff member scooped them out. Resident #3 stated the staff member came to them and told them they would assist them with finding an apartment and stated they had helped other residents in the past. Resident #1 stated the staff member asked for $75 dollars for an application fee and it just continued from there. Resident #1 stated the staff member was also coming into their room, taking their phone, and sending $500 dollars at a time to themselves. Resident #1 stated they heard the staff member did this to other residents but was unable to name them. Resident #3 stated the police informed them they were investigating but no one had followed up with them. Resident #3 stated they just want their money back as they planned on using that for furniture once discharged from the facility. Resident #3 was asked to show surveyor their cash app application and stated they did not know how to pull up the information. During an interview on 11/20/24 at 11:34 AM, the Director of Nursing stated the transportation worker did not work for the facility, they worked for the Dialysis center that is operated by a different management. The Director of Nursing stated the transportation worker came upstairs to transport resident's downstairs to the dialysis center. The Director of Nursing stated they could not conclude misappropriation for Resident #1 because they did not know what conversation was held between Resident #1 and the transportation worker. The Director of Nursing stated they put psych support in place for Resident #1 and contacted the police department, but the transportation worker is not an employee of the facility. During an interview on 12/09/24 at 2:25 PM, the Administrator stated they ensured all staff were in-serviced on abuse/misappropriation and how to interact with residents following Resident #3's misappropriation. The Administrator stated the transportation worker was also no longer allowed in the building. The Administrator stated they spoke with the director of the dialysis center, and going forth residents will be brought to the elevator by the facility staff to be picked up by the dialysis transportation staff. This will prevent the dialysis staff from entering the residents' rooms. The Administrator stated staff have been instructed to have dialysis residents wait by the elevators for pick up. An attempt to contact the transportation worker by phone 11/21/24 at 1:06 PM was unsuccessful. Phone number was no longer in service. 10NYRCC 415.4(b)(1)(i)

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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. 44266 Based on record review and interviews conducted during an abbreviated survey (NY00326265), the facility did not ensure a resident received treatment and care in accordance with professional standards of practice. This was evident for 2 of 3 Residents (Resident #1, #4) reviewed for quality of care. Specifically, the facility did not ensure a timely gynecological appointment for Resident #1 who had episodes of vaginal bleeding and a pelvic ultrasound result with a service date 3/20/23 showed enlarged extremely heterogeneous lobulated uterus most likely due to multiple fibroids. Resident was transferred to the hospital on 6/20/2023 for vaginal bleeding; 2) Resident #4 was admitted to the facility with intravenous antibiotic for infection on 6/6/2023. Resident #4's intravenous antibiotic infusion did not begin until 6/9/2023 after the resident's family representative brought it to the attention of facility staff. Findings include: The facility undated policy on Quality of Care documented the facility will ensure it identifies and provides the needed care and services that are person centered, in accordance with the resident's/patient's preferences, goals for care and professional standards of practice that will meet each resident's/patient's physical, mental, and psychosocial choices. Resident #1 was admitted with diagnosis including but not limited to Parkinson's Disease, Essential Hypertension and Type 2 Diabetes. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 06/16/23 revealed the resident did not have a Brief Interview for Mental Status (BIMS) score and was rarely/never understood. Resident #1 was totally dependent for eating, bed mobility, transfers, and activities of daily living. Review of a Palliative Care consult note dated 6/7/2022 documented palliative care was discussed with Resident #1 and their family representative and for now Resident #1's family representative would like the resident to continue to receive all necessary medical treatments including Cardiopulmonary Resuscitation and for Resident #1 to be comfortable on palliative care. Review of monthly palliative care consult dated 4/25/2023 documented Resident will continue with the Palliative Plan of care. Monitor for pain every shift, follow up monthly. The facility did not provide Palliative Care Plans with specified care for Resident #1. Review of Nurse Practitioner Progress Note dated 03/20/23 documented Resident #1 was seen and examined for follow-up of vaginal bleeding. Resident #1 not in any apparent distress. Resident #1 not on any anticoagulants. Resident #1 Complete Blood Count reviewed and awaiting abdominal ultrasound. Resident #1 had fibroids with last bleeding episode in December. Continue to monitor for bleeding and add stool for occult blood. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Facility Progress Note dated 04/13/23 documented Resident #1 noted with large clot discharge from vagina during Activities of Daily Living care. Medical Doctor made aware, and order received for immediate blood draw for a Complete Blood Count, Complete Metabolic Panel and Ultrasound of the pelvis. Resident #1 no acute distress noted. Review of Health Status Progress Note dated 04/15/23 documented Resident #1 recent pelvic ultrasound results are in, and show enlarged extremely heterogeneous lobulated uterus most likely due to multiple Fibroids. There is a hyper vascular mass which may be arising. Primary Medical Doctor was made aware and ordered gynecology consult. Review of Medical Visit Progress Note dated 04/16/23 documented Resident #1 was seen due to vaginal bleeding. Medical Doctor documented Hemoglobin was 9.6 on 04/13/23 and 11.5 on 03/17/2023 (Normal hemoglobin levels range between 12.1 to 15.1 g/deciliter). Review of Resident #1's Physician Order's dated 05/01/23 documented Obstetrics/Gynecology appointment scheduled for 05/05/24 at 11:00 AM. Review of Nursing Progress Note dated 05/05/23 documented Resident #1's appointment for gynecology visit was cancelled today, per the clinic they could not accommodate a resident that uses a Hoyer lift. Will reschedule appointment, Medical Doctor notified and will continue to monitor. Review of Medical Visit Progress Note, dated 05/27/23 documented Resident #1 was seen for follow up related to vaginal clot. Resident was not able to go to Gynecology appointment. Resident #1 has not had repeated vaginal bleed. Will continue to monitor. Review of Alert Progress Note dated 06/19/23 documented Resident #1 noted with another episode of vaginal bleeding during AM care (a large amount). Unable to obtain Gynecology appointment due to resident's weight and mode of transfer. Resident #1's daughter requested that Resident #1 be transferred to the emergency room for further evaluation. Review of Alert Note dated 06/19/23 by Nurse Practitioner documented hold the transfer of Resident #1 to hospital. Nurse Practitioner called and spoke to Resident #'s1 daughter who agreed to get an appointment at a Obstetrics/Gynecology clinic that could accommodate Resident #1 and a Hoyer lift the next day. Nurse Practitioner ordered a stat lab of Comprehensive Blood Count, Complete Metabolic Panel, Review of Medical Visit Progress Note dated 06/19/23 documented Resident #1 noted to have continued vaginal bleeding today. Plan for outpatient appointment delayed as outpatient facility unable to accommodate wheelchair with Hoyer lift. Discussed plan with nursing and Resident #1 daughter. There was no documented evidence that the residents order to see a Gynecologist since 05/01/2024 was followed through. Review of Discharge Progress Note dated 06/20/23 documented Resident #1 was transferred to the emergency room for evaluation following episodes of vaginal bleeding (moderate to large). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 3:39 PM with Resident #1's Family Member stated they got a call in March 2023 from the facility stating Resident #1 was having vaginal bleeding. Resident #1's Family Member stated the facility stated they would monitor the resident. Resident #1's Family Member stated Resident #1 started to bleed again and they were contacted by the Nurse Practitioner and was told they would get her a gynecology appointment. Resident #1's Family Member stated from March through June it was reported they were trying to get Resident #1 a gynecology appointment, but the appointments have been cancelled due to Resident #1 transfer status. Resident #1's Family Member stated Resident #1 started bleeding again in June and they asked for Resident #1 to be sent to the hospital. Resident #1's Family Member stated the facility did not want to send Resident #1 to the hospital even though their Hemoglobin (protein that carries oxygen in your blood) had dropped. Resident #1's Family Member stated the facility eventually sent Resident #1 to the hospital after they threatened to sue the facility. During an Interview on 11/18/24 at 2:56 PM, the Attending Physician stated Resident #1 was sent to the Gynecologist but was unable to be seen due to being bed bound. Attending Physician stated due to Resident #1's advance age and chronic medical conditions they suggested staff continue to try to get a Gynecologist appointment. Attending Physician stated since it was very difficult to get Gynecologist appointments. they feel Resident #1 should have been sent to the hospital for a follow up, but most hospitals will not accept a resident without an underlying issue. The Attending Physician stated due to Resident #1's age they were checking labs and monitoring the resident continuously while looking for another gynecologist. Attending Physician stated Resident #1's hemoglobin/hematocrit would have needed to be low for the hospital to take Resident #1. During an interview on 11/18/24 at 3:15 PM, the Nurse Practitioner stated Resident #1 had multiple gynecology appointments that were scheduled and they either went and couldn't be accommodated or the appointment was cancelled due to transfer status. Nurse Practitioner stated staff were continuously trying to find different gynecologist for Resident #1. Nurse Practitioner stated Resident #1 had a history of fibroids and intermittent bleeding for years and at the time of the vaginal bleeding they suspected the resident had cancer . Nurse Practitioner stated they did not feel Resident #1 should have been sent to the emergency department because they were still eating, drinking and was at their baseline. Nurse Practitioner stated Resident #1 needed a biopsy and there was no guarantee that would get done by sending Resident #1 out to the emergency room . 2) Resident #4 was admitted with diagnoses including but not limited to Acute Chronic Respiratory Failure, Type 2 Diabetes, Parkinson Disease, Stage 4 kidney disease and Heart Failure. The Minimum Data Set (MDS, an assessment tool) dated 06/14/23 documented the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 11/15, associated with intact cognition. Resident #4 was totally dependent for transfers and eating and required extensive assist for bed mobility, dressing and personal hygiene. Review of Resident #4's admission Medication Reconciliation Form, printed 06/06/23 documented to continue Ampicillin/Sulbactam (intravenous antibiotic) 1.5 grams every eight hours for 14 days. Last dose in hospital administered at 7:00 PM on 06/06/23. Review of Admission Progress Note dated 06/07/23 documented Resident #4 was admitted to the facility with Percutaneous Enteral Tube(PEG) and IV line in left forearm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's Medication Order Summary dated 06/09/23 documented an order for Unasyn Injection Solution Reconstituted 1.5 GM, use 1 gram every 12 hours for wound infection for 14 days, start date 06/09/23. Review of Resident #1's Medication Administration Record revealed an order dated 06/09/23 for Unasyn Injection Solution Reconstituted 1.5 GM, use 1 gram every 12 hours for wound infection for 14 days and administered on 06/09/23 at 6:00 PM. Review of Medical Visit Progress Note dated 06/13/23 documented a recommendation in the chart by infectious disease to start antibiotics for 4 weeks from May 2023 and ending June 2023. During an interview on 12/09/24 at 4:18 PM, the Director of Nursing stated medications are reviewed by the admitting staff, then followed up by a review from the incoming supervisor and then they are reviewed with the physician. The Director of Nursing stated their expectation is for all medications to be reconciled accurately. During an interview on 12/09/24 at 12:41 PM with Registered Nurse #1, they stated Resident #4's family representative contacted the facility and notified them that Resident #1 was supposed to be on an intravenous antibiotic. Registered Nurse #1 stated they could not recall who notified them but stated they went on to inform the physician. Registered Nurse #1stated the physician stated they would look over Resident #1's admission forms and start the order if needed. During an interview on 12/09/24 at 2:44 PM, the Primary Physician stated when a resident is admitted to the facility, they will reconcile the resident's medications with their discharge orders and with staff when it is submitted. The Primary Physician stated they had no explanation for why Resident #1's antibiotic was not started after their admission to the facility. The Primary Physician stated Resident #4 had been on the antibiotic for four weeks at the time it was missed. The Primary Physician stated missing the medication would not have put Resident #1 at risk. 10NYCRR 415.12