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	12/18/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50766 Based on observation, interview, and record review during the recertification and abbreviated surveys from 12/11/24 to 12/18/24, the facility did not ensure residents had the right to a dignified experience for 1 of 1 resident (Resident #90) reviewed for dignity. Specifically, the fitted mattress sheet on Resident #90's bed was observed stained and not changed for six days. The findings include: The policy titled Rights/Dignity Resident dated 6/24 documented promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in recognition of a person-centered care approach. 1)Resident #90 was admitted with diagnoses including neuromuscular dysfunction of bladder, unspecified retention of urine, and acquired absence of kidney. The Annual Minimum Data Set (resident assessment) dated 10/23/24 documented Resident #90 was cognitively intact. The care plan titled Resident is Dependent on staff daily for Activities of Daily Living needs, revised 10/15/24, documented needs will be met by staff as evidenced by being well groomed/appropriately dressed daily, and supervision or touching assistance with toileting, hygiene, and showering. During observation and interview on 12/11/24 at 3:00 PM, 12/12/24 at 11:34 AM, and 12/13/24 at 10:03 AM Resident #90's mattress fitted sheet was observed with stains on the left side lower part of bed. Resident #90 stated their sheets were changed infrequently, and staff informed them there was a linen shortage. During an interview on 12/16/24 at 2:27 PM Certified Nurse Aide #29, stated they routinely worked on the unit and were familiar with Resident #90. They stated they showered Resident #90 on Saturday 12/14/24 and changed the sheets on Resident #90's bed. They stated they had sufficient supplies on the unit including sheets and blankets. They stated if there were insufficient supplies, staff would go to the laundry department or call the laundry/housekeeping supervisor and they would bring the needed supplies to the unit. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 12/16/24 at 3:03 PM, Registered Nurse #28 stated on Unit #2 there could be occasional shortages of towels, sheets and gowns. They stated if staff observed a shortage of items, housekeeping / laundry should be called, and the needed items should be delivered to the unit. An observation of Resident 90's soiled sheet with Registered Nurse #28 was conducted during interview and they stated they were not aware Resident's #90's sheets were not changed. They stated they would address the soiled sheet with Certified Nurse Aide #29. During an interview on 12/17/24 at 1:10 PM, the Director of Housekeeping stated all laundry was completed in the facility. They stated linens were delivered to each unit twice daily. The Director of Housekeeping stated the laundry department would deliver fresh linens immediately to the unit should additional supplies be needed. They stated inventory was maintained and new orders were placed if the facility ran low on linens. 10 NYCRR 415.3 (d)(i)(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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50816 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00354189) surveys from 12/11/2024 to 12/18/2024, the facility did not ensure all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency. Specifically, a resident-to-resident altercation involving Resident #42 and Resident #273 on 9/12/24 at 2:50 PM was not reported to the State Survey Agency until 9/12/24 at 6:17 PM. The findings are: The facility policy titled Abuse, Neglect, Exploitation Prevention & Elderly Justice Act updated 01//2024 documented the New York State Department of Health/Nursing Home Complaint Hotline was to be called to report any physical altercations, alleged abuse. neglect and/or mistreatment and injury of unknown origin. Calls must be placed within indicated time frame to prevent the facility being cited for non-compliance with Reporting. The Elder Justice Act requires nursing homes to report all residents' altercations. The time frame for reporting is 2 hours if there is bodily injury. The Accident/Incident Report with a date and time of occurrence 9/12/2024 at 2:50 PM documented an altercation between Resident #42 and Resident #273 on the 2nd floor elevator. Summary of investigation documented Resident #42 was calm and quiet while visiting a friend on the 2nd floor prior to the incident. Resident #273 was on the 2nd floor elevator to go to a dialysis session. Resident #42 tried to enter the elevator quietly when Resident #273 stopped them. This appeared to have aggravated Resident #42 and triggered a heated verbal exchange which abruptly escalated to physical altercation. Staff immediately intervened; the altercation was deescalated as both residents were brought back to their respective units. Resident #273 presented with slight blood from a cut on the lip and complained of pain on the right scapula. The physician was notified and ordered treatment to the affected lip and x-ray of the right scapula. Resident #273 refused hospitalization and was too upset to go to dialysis. Resident #42 was transferred to the hospital for evaluation as per physician order. Resident # 42 was admitted with diagnoses including but not limited to Schizophrenia, Depression, and dementia. The Minimum Data Set assessment dated [DATE] documented Resident #42 had moderate cognitive impairment, was ambulatory with use of a walker. Resident #273 was admitted with diagnoses including but not limited to End Stage Renal Disease requiring hemodialysis, Chronic Obstructive Pulmonary Disease and anxiety disorder. The Minimum Data Set assessment dated [DATE] documented Resident #273 was cognitively intact, and dependent with wheelchair use. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview on 12/18/24 11:39 AM the Director of Nursing, stated they were notified of the incident on 9/12/24 at around 2:50 PM and reported at 6:17 PM. The incident resulted in a bloody lip to one of the residents, the other was sent out for a psychiatric evaluation, and the police were notified. The Director of Nursing stated they were aware of the need to report the incident within 2 hours and should have reported sooner. 10 NYCRR 415.4(b)(2)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00352882) survey from 12/11/2024 to 12/18/2024, the facility did not ensure a resident's representative was notified in writing of a resident's facility initiated discharge. This was evident for 1 (Resident #255) of 5 residents reviewed for Discharge. Specifically, Resident #255 received a Notice of Discharge on 12/16/2024 and there was no documented evidence that a copy of the discharge notice was not sent to the resident representative. The findings are: The facility policy titled Transfer or Discharge Notice dated 6/2024 documented the resident and/or representative will be notified in writing of the reason for the resident's transfer or discharge. Resident #255 had diagnoses of medically complex conditions and depression. The Quarterly Minimum Data Set assessment dated [DATE] documented esident #255 was cognitively intact, required supervision for transfers, ambulationg, resident/family were involved in assessment, a discharge plan was in place, overall goal was return to community, no referrals were requested. On 12/11/2024 at 11:19 AM, the Ombudsman was interviewed and stated their office had concerns with the facility's discharge notification process. The facility received reports from residents that a Notice of Discharge had been issued and the Ombudsman's office had not received a copy of the notice from the facility. A Discharge Notice dated 12/16/2024 documented the interdisciplinary team determined Resident #255 would be discharged to the community on 1/15/2025. The resident's health improved sufficiently so the resident no longer needed the services provided by the facility as evidenced by completion of subacute rehabilitation and exhaustion of Medicare coverage. On 12/17/2024 at 9:25 AM, the Ombudsman stated during a telephone interview that Resident #255 originally received a Notice of Discharge on 12/13/2024 from the Social Worker and the Ombudsman's Office did not simultaneously receive a copy of the notice. Resident #255 contacted the Ombudsman's Office yesterday and reported the Social Worker gave them a revised copy of the discharge notice. On 12/17/2024 at 1:18 PM, Resident #255 was interviewed and stated they received a Notice of Discharge from the Social Worker and was not in agreement with the facility-initiated discharge plan. Resident #255 stated the address on the Notice of Discharge was incorrect and listed their daughter's address which was only Resident #255's mailing address and not their residence in the community. Resident #255 stated they did not discuss the Notice of Discharge with their daughter. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/2024 at 1:32 PM, Social Worker #1 was interviewed and stated they issued a revised Notice of Discharge to Resident #255 on 12/16/2024 and emailed a copy of the notice to the Ombudsman's Office. Social Worker #1 spoke with Resident #255's daughter on previous occasions and did verify that Resident #255's community address was still available. Social Worker #1 was unable to contact Resident #255's daughter to inform them of the Notice of Discharge and to discuss specific discharge plans for Resident #255 to return to the community. Social Worker #1 stated they sent a copy of the Notice of Discharge to Resident #255's daughter via regular uncertified mail and had no documented evidence of the mailing. On 2/18/2024 at 4:57 PM, the Administrator was interviewed and stated the Social Worker provided a Notice of Discharge to the resident, Ombudsman, and the resident's representative. The Administrator stated there was no documented evidence the notices were mailed to resident representatives. The Administrator stated they were involved in the interdisciplinary team discussions regarding resident discharges and was aware of the Notice of Discharge issued to Resident #255 on 12/16/2024. 10 NYCRR 415.3(i)(1)(iii)(a-c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 43478 Based on record review and interview conducted during the recertification and abbreviated (NY00336283) survey from 12/11/2024 to 12/18/2024, the facility did not ensure that Minimum Data Set 3.0 Assessments accurately reflected the residents' status. This was evident for 1 (Resident #276) of 10 residents reviewed for Pressure Ulcers, 1 (Resident #217) of 6 residents reviewed for Accidents, and 1 (Resident #320) of 5 residents reviewed for Discharge. Specifically, 1) the Minimum Data Set 3.0 assessment inaccurately documented that Resident #276's facility acquired pressure ulcer and facility acquired deep tissue injury were present on admission 2) the Minimum Data Set 3.0 assessments did not identify Resident #217 as an active smoker, and 3) Resident #320 had a facility-initiated discharge to the community and the Discharge Minimum Data Set 3.0 assessment inaccurately documented the resident was discharged to a short-term general hospital. The findings are: The undated facility policy, Minimum Data Set guideline for completion documented the facility will ensure accurate and timely completion of Minimum Data Set/Care Plan for all residents in accordance with the Federal and State Operations Manual. All members of the interdisciplinary team are responsible for reviewing all resident strengths, problems needs and plan of care. 1) Resident #276 had diagnoses including but not limited to dysarthria (difficulty with speech), dementia, and cerebral vascular accident (stroke). The 7/6/2023 Admission Minimum Data Set (resident assessment) documented Resident #276 had no pressure ulcers or wounds. The 10/6/2023 Quarterly Minimum Data Set documented Resident #276 had no pressure ulcers or wounds. The 1/6/2024 Quarterly Minimum Data Set documented Resident #276 had no pressure ulcers or wounds. The 3/13/2024 Minimum Data Set discharge assessment documented Resident #276 had 1 unstageable pressure ulcer present on admission and 1 deep tissue injury present on admission. 40686 2) Resident #217 had diagnoses of diabetes mellitus and chronic obstructive pulmonary disease. The 8/9/24 Care Plan related to smoking documented Resident #217 was a known smoker and would be educated on the risks of smoking. The 8/9/24 Nursing Note documented Resident #217 requested to smoke in the morning. The 8/15/24 Quarterly Minimum Data Set was not coded to indicate if Resident #217 was an active smoker at the time of assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #320 had diagnoses of diabetes mellitus, trigeminal neuralgia, and cervical disc disorder. The Social Work Note dated 10/22/2024 documented Resident #320 was provided with the address of a homeless shelter and was informed their discharge date from the facility would be 11/10/2024. The Social Work Note dated 11/6/2024 documented Resident #320 was discharged from the facility and provided transportation to the airport. The Minimum Data Set, dated dated dated MDS 11/6/24 documented Resident #320 was discharged to the hospital. On 12/17/2024 at 1:43 PM during an interview, the Minimum Data Set Director reviewed the Minimum Data Set 3.0 discharge assessment for Resident #276 dated 3/13/2024 and stated the resident's wounds were not present on admission, the assessment incorrectly coded the resident as having the wounds upon admission to the facility, and the assessment required modification to accurately describe Resident #276's condition. The Minimum Data Set Director stated the assessors in their department were responsible for inputting resident clinical data and reviewing the assessments for completion and accuracy prior to assessment transmission and submission. On 12/18/2024 at 4:57 PM, the Administrator was interviewed and stated they were unaware Minimum Data Set Assessments were submitted with inaccurate resident information. The discharge assessment for Resident #320 was inaccurate because Resident #320 was served a 30-day discharge notice and was discharged to the community, not a acute-care hospital. They stated the assessors obtained information by referring to resident's medical records, and any discrepancies on the Minimum Data Set assessments were unintentional mistakes. 10 NYCRR 415.11(b)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 43478 Based on record review and interview conducted during the recertification and abbreviated survey (NY 00344069) from 12/11/24 to 12/18/24, the facility did not ensure each resident was provided with the necessary care and services to ensure the resident's ability to communicate their needs to staff was available. This was evident for 1 of 2 residents (Resident #275) reviewed for communication. Specifically, Resident #275 who spoke Spanish as their primary language was not provided with a Spanish translator as indicated in the resident's Care Plan. Additionally, the staff did not know how to access a translation device or services. The findings are: The policy titled Communication/Language documented make every effort to provide interpretive services for residents whose primary language is other than English. The facility staff will strive to ensure meaningful language access and communication services are available for all limited English proficient persons. Resources available for language access service during hours of facility operation, include the following: a)Language Access Vendor o Telephonic Interpreting Services/Video Remote Interpreting Services. b) Communicative Devices/Language Communication Boards are available on Units. Resident #275 had diagnoses including cerebral infarct (stroke), diabetes mellitus, and muscle weakness. The 5/31/24 Baseline Care Plan documented Resident #275 could communicate easily with staff, understood staff, wanted an interpreter to communicate with a doctor or health care staff, and their primary language was Spanish. The 6/1/24 Care Plan titled Resident has an Interpretation Need documented the resident would communicate via an interpreter and the resident's preferred language was Spanish. The 6/3/24 Medicare-5 day Minimum Data Set (resident assessment) documented Resident #275 had intact cognition, adequate hearing and clear speech, was able to make themselves understood and understood others. The resident and family participated in the assessment. On 12/17/24 at 12:21 PM during an interview, the Director of Nursing stated that only during one evening, the Certified Nurse Aide who provided care to the resident was proficient in speaking Spanish. The Director of Nursing stated the other Certified Nurse Aides who provided care to the resident were not proficient in speaking Spanish. The Director of Nursing stated they were unsure whether the Certified Nurse Aide instructions documented the resident's need for interpretive services. On 12/17/24 at 1:58 PM during a follow-up interview, the Director of Nursing stated the Certified Nurse Aide instructions for Resident # 275 did not document the resident was Spanish speaking and required interpretive services or devices. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 3:41 PM during an interview, Certified Nurse Aide #2 stated if a resident was Spanish speaking, it was not documented on the Certified Nurse Aide instructions. They stated there were not enough Spanish speaking Certified Nurse Aides to provide care to all the Spanish speaking residents. They stated they had not been in-serviced on using the language translation devices. On 12/17/24 at 4:07 PM during an interview, Certified Nurse Aide #4 stated they provided care to the resident. They stated they were not proficient in Spanish. They stated there was no information on the Certified Nurse Aide Instructions to inform the aides whether residents were Spanish speaking or instructions on how to communicate with Spanish speaking residents. They stated they asked a Spanish speaking Certified Nurse Aide to translate as needed. They stated they had not been in-serviced on using language translation devices. On 12/18/24 at 9:56 AM during an interview, the Administrator stated the nurse was responsible for making the Certified Nurse Aide assignments. They stated the nurse should weigh all priorities equally when making assignments. They stated Spanish speaking was only one of the priorities taken into consideration. 10 NYCRR 415.12(a)(c)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on observation, record review, and interview during the recertification and abbreviated (NY00336283) surveys from 12/11/24 to 12/18/24, the facility did not ensure residents at risk for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, and prevent new ulcers from developing for 2 of 10 residents (Residents #276 and #115) reviewed for Pressure Ulcers. Specifically, 1) for Resident #276 at risk for skin breakdown there was no documented evidence that preventative measures as per care plan and the use of heel booties as per the 1/30/24 physician order were implemented prior to the development of a 2/9/24 left heel pressure ulcer and 3/1/24 left dorsal foot deep tissue injury and 2) Resident #115's air mattress pressure was not inflated according to the Resident's weight. The findings are: The Policy and Procedure titled Pressure Injury Prevention and Management dated 5/2024 documented a resident who enters the facility without pressure injury does not develop pressure injury unless individuals clinical condition demonstrates they were unavoidable. It is the responsibility of the facility staff via the interdisciplinary team to recognize any resident who is at risk for pressure ulcer development and initiate appropriate preventive measures. The Air Mattress Support Surface Policy revised on 6/2024 documented ensure that residents who have need for bed redistributing support surfaces to promote comfort, prevent skin breakdown, promote circulation and provide pressure relief or reduction will receive treatment as ordered. A physician's order is required for the use of an air mattress, use the pressure adjustable knob to give maximum resident comfort based on the resident's weight in pounds (lbs.) as applicable, air pressure inflation monitoring should be checked and documented on the Treatment Administration Record by nurses each shift. 1) Resident #276 had diagnoses including but not limited to dysarthria (difficulty with speech), dementia, and cerebral vascular accident. The 6/30/23 Care Plan, Resident is dependent on staff daily in meeting ADL needs with admitting diagnoses of activity intolerance, impaired balance, limited mobility, and stroke. Interventions included to provide 2-person dependent assistance with bed mobility. The 6/30/23 Care Plan Potential Impaired Skin Integrity: Resident is at risk of developing impaired skin integrity as evidenced by undocumented Braden score, bladder and bowel incontinence, impaired mobility, cognitive deficits, non-ambulatory status, and functional decline. Interventions included to turn and reposition every 2-3 hours. The 10/19/23 Nursing Braden Scale for Predicting Pressure Sore Risk Assessments score of 17 documented Resident #276 was at risk for skin breakdown. The December 2023/January 2024 Point of Care Audit Reports (Certified Nurse Aide documentation) did not provide documented evidence of turning and repositioning or off-loading Resident #276's heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/4/24 Nursing Braden Scale for Predicting Pressure Sore Risk Assessments score of 17 documented Resident #276 was at risk for skin breakdown. The 1/6/24 Quarterly Minimum Data Set (resident assessment) documented Resident #276 had severely impaired cognition, limitations in range of motion to upper extremity on one side and lower extremities on both sides, required substantial/maximal assistance with rolling left and right and had no pressure ulcers or wounds. The 1/1/24 through 1/29/24 Progress Notes did not include documentation of preventive measures taken to address the resident's risk for skin breakdown. The Physician order documented 1/30/24 heel booties. The January and February 2024 Treatment Administration Records did not provide documented evidence of turning and repositioning, heel booties, or off-loading Resident #276's heels. The 2/2/24 Weekly Wound Rounds/Team Assessment Medical Note documented left heel scab, date of onset 2/1/24, measurements: length 2.0, width 1.0, depth 0. Wound bed 100% dry scab. Recommended Primary Dressing: Skin Prep with bordered gauze daily and prn. The 3/1/24 Weekly Wound Rounds/Team Assessment Medical Note documented: 1) unstageable pressure injury of the left heel, date of onset 2/2/24, length 4.0, width 4.0, depth undetermined. wound bed 50% eschar, 50% blister. Recommended primary dressing: betadine and bordered gauze daily and prn. 2) pressure injury-deep tissue injury to left dorsal foot. date of onset 3/1/24. length 3.0, width 2.5, depth 0. wound bed 50% eschar, 50% blister. Recommended primary dressing: dry protective dressing daily and prn. The 3/13/24 Minimum Data Set (resident assessment) discharge assessment documented Resident #276 had 1 unstageable pressure ulcer and 1 deep tissue injury. On 12/16/24 at 6:05 PM during an interview, Registered Nurse Supervisor #1 stated heel booties were ordered [DATE], 2 days prior to identification of the left heel scab. Registered Nurse Supervisor #1 reviewed the Point of Care Audit Reports (Certified Nurse Aide documentation) and stated there was no documented evidence that turning and repositioning or offloading Resident #276's heels occurred in December 2023 or January 2024. Registered Nurse Supervisor #1 stated there was no documented evidence of Resident #276 having been provided an air mattress. Registered Nurse Supervisor #1 stated there were no documented interventions in place to prevent skin breakdown on the Certified Nurse Aide tasks. They stated turning and positioning was documented in the Potential Impaired Skin IntegrityCare Plan, but it was not documented in the Certified Nurse Aide tasks or on the Treatment Administration Record. Registered Nurse Supervisor #1 stated that turning and positioning should have been documented in the Certified Nurse Aide tasks. On 12/16/24 at 6:23 PM during an interview, the Director of Nursing stated interventions for pressure ulcer prevention should have been in place to prevent skin breakdown such as heel booties, turning and repositioning, off loading, and/or air mattress, but the interventions were not in place. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24 at 1:24 PM during an interview, the Wound Nurse stated Resident #276 had no wounds prior to February 2, 2024. The Wound Nurse stated no interventions were documented to prevent skin breakdown. The Wound Nurse stated that heel booties were ordered on 1/30/24, but that was only 2 days prior to the reported left heel scab, and would not have been sufficient to prevent the scab from developing in the 2 day time period. The Wound Nurse stated that the unit managers were responsible to enter orders for skin breakdown prevention. The Wound Nurse stated that the Registered Nurse Unit Manager who performed the Braden Assessment on 1/4/24 should have initiated and implemented interventions to prevent skin breakdown based on the Braden Score of 17 which documented that Resident #276 was at risk for skin breakdown. The Wound Nurse stated Resident #276 developed 2 wounds on the left foot at the facility, and both wounds were avoidable. On 12/18/24 at 10:40 AM during an interview, the Wound Care Physician stated it was possible that Resident #276's left heel and left dorsal foot wounds could have been avoided if off-loading or heel booties or turning and repositioning or an air mattress had been in place. The wound care physician stated that preventive interventions should have been in place, since the resident was at risk for skin breakdown. 50816 2) Resident #115 had diagnoses including chronic obstructive pulmonary disease, unspecified dementia and Alzheimer's disease. The 9/13/24 Braden Scale for Predicting Pressure Ulcer Risk Assessment score of 14 documented Resident # 115 was at risk for skin breakdown. The 10/05/2024 Care Plan titled Impaired Skin Integrity Pressure Ulcer/Injury documented the resident had impaired skin integrity as evidenced by a Stage 3 pressure injury on the left heel. The Physician Order dated 11/23/24, documented skin checks every day shift, Hydrogel external gel (wound dressing) apply to left heel Stage 3 topically every evening shift for wound care. Cleanse with normal saline, pat dry, apply hydrogel, calcium alginate and cover with foam dressing. The Minimum Data Set (resident assessment tool) dated 11/28/2024, documented Resident # 115 had severely impaired cognitive skills, was dependent on staff for activities of daily living, at risk of developing pressure ulcer, had a Stage 3 pressure ulcer, and had a pressure reducing device for the bed. The 12/06/2024 weight record documented Resident #115 weight was 181.0 pounds. The Physician Order dated 12/13/24 documented air mattress. During observation on 12/12/24 at 8:57 AM, 12/13/2024 at 9:24 AM and 12/27/2024 at 9:18 AM, Resident # 115 was in bed, the air mattress was on and the dial was set at 350 pounds. There is no documented evidence in the December 2024 Treatment Administration Record that the air pressure inflation monitoring was checked. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/17/24 at 09:21 AM Certified Nursing Assistant #11, stated the Maintenance Department took care of the air mattress and the resident was weighed during the first week of the month. During an interview on 12/17/24 at 10:35 AM Registered Nurse #7 stated they did not check the air mattress dial. During an interview and observation on 12/17/24 at 10:44 AM, in Resident #115's room with the Director of Nursing and Registered Nurse #7, the Director of Nursing checked the air mattress dial and stated the dial was set at 350 pounds. The Director of Nursing asked Registered Nurse #7 to check the weight of Resident #115 in the electronic health record. Registered Nurse #7 checked the weight and stated the resident's weight was 181 pounds. The Director of Nursing stated they were unable to provide documentation that the air mattress was checked and documented by nurses each shift in the Treatment Administration Record as per facility policy. 10NYCRR 415.12(c)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview and record review conducted during an abbreviated survey (NY00348967), the facility did not provide person-centered care and services necessary to maintain the highest practicable physical, mental, and psychosocial well-being for one of six residents (Resident #271) reviewed for Accidents. Specifically for Resident # 271 with a history of pneumonitis due to inhalation of food/vomit and dysphagia the facility did not develop and/or implement a plan to address the resident's individual needs and minimize risk of potential choking hazards as per [DATE] hospital visit summary swallowing recommendations for a soft, bite-sized diet texture, mildly thick liquids with no straw, and intermittent supervision to monitor for aspiration and after Resident #271 verbalized a [DATE] request for chopped texture proteins due to difficulty with chewing chicken and beef. Additionally, the facility did not thoroughly investigate an incident to rule out choking after Resident #271 was found unresponsive in their room on [DATE] after being served their lunch meal tray. The findings are: The policy titled Accidents and Incidents Investigating and Reporting dated ,d+[DATE] documented all accidents or incidents involving residents shall be investigated using the Report of Incident/Accident Form including the circumstances surrounding the accident or incident, the names of witnesses and their accounts, and other pertinent data as necessary or required. The facility policy titled Aspiration Precautions dated ,d+[DATE] documented aspiration precautions were defined as measures taken to reduce the risk of aspiration during eating, drinking, and other activities. Nursing staff were responsible for monitoring residents for signs of aspiration risk, implementing precautions and communicating changes in condition. Speech Language Pathologists assess swallowing function and recommend appropriate dietary modifications and interventions. Provide direct supervision for residents with high aspiration risk and observe for signs of difficulty such as coughing and choking. Documents observations in the resident's medical record. Resident #271 had diagnoses of cerebral infarction with left hemiplegia and hemiparesis, aphasia, and dysarthria. The Hospital Visit Summary dated [DATE] documented Resident #271 had a speech language pathology clinical swallowing evaluation on [DATE]. The evaluation documented Resident #271 had a past medical history of pneumonitis due to inhalation of food and vomit and dysphagia. The swallowing recommendations were for Resident #271 to receive a soft, bite-sized diet texture, mildly thick liquids with no straw, and intermittent supervision to monitor for aspiration. Physician Orders dated [DATE] documented Resident #271 was ordered to be placed on aspiration precaution and receive a regular texture diet with thin liquids. A Speech Language Pathology Screen dated [DATE] and [DATE] documented Resident #271 was ordered regularly textured food consistency with thin liquids, was not on a mechanically altered diet, and was recommended to receive speech-language services. A swallowing evaluation was not recommended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Speech Therapy Note dated [DATE], [DATE], and [DATE] documented Resident #271 presented with dysarthria, residual aphasia, was edentulous, and the goal of therapy was to improve speech intelligibility by improving coordination of phonation and speech respiration. Resident #271 swallowing function and diet consistency were not documented. A neurological status care plan initiated [DATE] documented Resident #271's diet be adjusted to accommodate chewing, swallowing, or eating issues to maximized independence and nutritional intake. A care plan related to poor oral hygiene initiated [DATE] documented Resident #271 was edentulous, and interventions included providing consulting with the dietician and Speech to change the resident's diet if the resident presented with chewing/swallowing problems. A speech therapy care plan dated [DATE] documented Resident #271 received a speech/language evaluation and treatment for cognition/speech/language. A care plan related to Resident #271's risk for aspiration dated [DATE] documented interventions including monitoring for signs and symptoms of coughing and choking, providing regular meals with thickener and ensuring adequate hydration and nutrition. A risk of malnutrition care plan dated [DATE] documented Resident #271 had varying oral intake and a recent hospitalization . Interventions to maintain adequate nutritional intake included monitoring and recording the resident's intake and monitoring and documenting as needed signs and symptoms of dysphagia, pocketing, choking coughing, drooling, holding food in mouth, or several attempts as swallowing. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #271 had mild cognitive impairments, had no difficulty chewing, required setup assistance with eating, did not receive speech therapy services in the 7 days prior to assessment, did not receive a mechanically altered diet, and did not display symptoms of a swallowing disorder. The Dietary Note dated [DATE] documented Resident #271 verbalized experiencing difficulty with chewing chicken and beef as well as coughing when drinking thin liquids. Resident #271 requested chopped texture protein, mashed potato instead of rice, and nectar thick liquids. The registered nurse supervisor and director of rehabilitation were made aware. There was no documented evidence the Speech Language Pathologist evaluated Resident #271 after [DATE]. Nursing Notes following [DATE] Dietary Note did not document Resident #271's oral intake and/or difficulty swallowing or eating. The Physician's Order dated [DATE] documented Resident #271's diet order was changed to regular texture with honey consistency liquids. The Certified Nursing Assistant Kardex Report as of [DATE] documented instructions to monitor Resident #271 and document and report as needed any signs and symptoms of dysphagia, pocketing, choking, coughing, holding food in the mouth, or several attempts at swallowing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Certified Nursing Assistant Accountability Record for June and [DATE] documented Resident #271 was provided with eating setup and/or clean up during meals. There was no documented evidence Resident #271's meal intake was monitored and recorded. There was no documented evidence the Certified Nursing Assistant Accountability Record for [DATE] and [DATE] that nursing staff monitored Resident #271 for signs and symptoms of dysphagia. The Treatment Administration Record for June and [DATE] documented Resident #271 was on aspiration precautions. The record did not require nursing staff signatures to verify aspiration precautions were provided to Resident #271. The [DATE] Complaint Tracking System intake NY 00348067 documented the facility reported at 12:50 PM, Resident #271 was found unresponsive in their room after being served their lunch meal tray, cardiopulmonary resuscitation was performed, and Resident #271 expired at 1:30 PM. The facility investigation was ongoing to rule out choking episode as the resident did not have any incident of having difficulty swallowing previously. The Investigative Report dated [DATE] documented Resident #271's cause of death was cardiopulmonary arrest. The statements from staff and summary did not document whether Resident #271 ate any portion of their lunch meal, if the resident had any food items in their mouth or airway and did not rule out aspiration as a possible contributing factor to Resident #271's cause of death. . On [DATE] at 3:22 PM, the Dietary Technician was interviewed and stated they were responsible for the resident's food preferences and assessments upon admission and readmission. The Registered Dietician can write diet orders but the Registered Dietician for the facility was away on vacation and on leave and not available. The Dietary Technician input the resident's food preferences into the kitchen menu system but does not input the consistency and texture of the diets. The Dietary Technician did not have a documented communication form or system with the registered Dietician. They communicated verbally regarding resident preferences or concerns related to diet orders. The Dietary Technician did not communicate with the Medical Doctors related to resident diets and only communicated with the nurses on the unit. The Dietary Technician stated they were not able to downgrade or change a resident's diet consistency in the kitchen menu system. The Speech Therapist was responsible for changing a resident's diet consistency and would communicate with a resident's aspiration precautions through a group chat for facility staff. Resident #271 reported to the Dietary Technician they had difficulty swallowing and requested their chicken and beef be cut into small pieces. The Dietary Technician stated they wrote their note during the weekend, manually wrote the resident's diet preference on their meal ticket for that evening, verbally told the Registered Nurse and the Director of Rehabilitation about the resident's need for a Speech Therapy evaluation, and texted the Speech Therapist, who was on vacation at the time. The Dietary Technician visited with Resident #271 a few days later and the resident appeared fine. The Dietary Technician did not follow up with the nursing staff to ensure a Speech Therapy evaluation was ordered and did not follow up with the Director of Rehabilitation. The Dietary Technician did not document their follow up with the resident in their notes and did not check the resident's chart to ensure a change in diet consistency was ordered. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 01:10 PM, the Speech Therapist stated they were responsible for overseeing resident diet orders and communicating any change in a resident's consistency to the kitchen and nursing staff. They assess residents for clinical signs of aspiration risk. Nursing staff can downgrade a diet for a resident if they are expressing or observed with difficulty in managing the diet texture they currently received. The Speech Therapist stated they were responsible for assessing and screening new admissions for cognitive function and speech function to determine and whether they can benefit from services. The Speech Therapist stated they usually assess new admission within 24 hours of their admission to the facility. They checked diet orders and any speech language referrals or recommendations from the hospital. The Speech Therapist stated they evaluated Resident #271 upon admission and must have missed the diet order for soft foods and thickened liquids from the hospital. The Speech Therapist stated they would have followed the order from the hospital and recommendations. Resident #271 was assessed on [DATE] and the Speech Therapist stated they determined the resident could tolerate the regular texture diet they were consuming for the 2 days since their admission to the facility. The Speech Therapist stated they did not receive any referrals or requested to see Resident #271 since discontinuing them from services in ,d+[DATE]. They were not aware that Resident #271 had any difficulties with managing their diet consistency. On [DATE] at 12:58 PM, Registered Nurse #36 was interviewed and stated resident #271 did not experience any difficulty with chewing their food or choking during their morning meal on [DATE]. Resident #271 was in their room and Registered Nurse #36 stated they checked the resident's blood sugar prior to lunch and the resident was stable with no concerns. Registered Nurse #36 had their diet consistency changed to thickened liquids but had a regular texture diet and did not express to the Registered Nurses that they had difficulty with their current regular texture diet. A resident on aspiration precautions should eat in the floor dayroom and be supervised by staff. The floor dayroom was closed due to renovations and all residents had to eat in their rooms during ,d+[DATE]. The nursing staff were instructed to round more regularly on residents who were on aspiration precautions to monitor and supervise residents for eating difficulties. On [DATE] at 1:38 PM, Certified Nursing Assistant #34 was interviewed and stated they found Resident #271 unresponsive when they went to their room to pick up the resident's lunch tray. Certified Nursing Assistant #34 stated they did not observe any food in or around the resident's mouth or on the resident's bed. They did not observe any signs of vomiting or drooling, and the meal tray appeared untouched. Certified Nursing Assistant #34 stated they were made aware of aspiration precautions by the nurse and rounded on residents more often during mealtime if the residents ate in their room. On [DATE] at 2:20 PM, the Director of Nursing was interviewed and stated they were unaware Resident #271 had a diagnosis of dysphagia on their Hospital Discharge Summary and that the hospital Speech Pathologist recommended a soft, bite-sized diet texture. The Director of Nursing stated they reviewed the Dietician's note regarding Resident #271's request for a downgraded diet and determined the Dietician did not communicate this information to the Registered Nurse or the Director of Rehabilitation to ensure Resident #271 received a Speech Therapy evaluation for downgraded diet texture. The Director of Nursing stated they were not aware that staff statements and their Investigative Report did not include information related to whether Resident #271 aspirated during the lunch meal. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:18 PM, Medical Doctor #1 was interviewed and stated they were Resident #271's attending physician and completed the resident's death certificate. Medical Doctor #1 stated they recall the nurse who reported the resident's death via telephone told Medical Doctor #1 that Resident #271 choked during the lunch meal on a piece of chicken. Medical Doctor #1 stated they did not include this as a cause of death and did not personally assess the resident upon their death on [DATE]. Medical Doctor #1 stated they did find the report concerning and reported it to someone in the nursing office but could not recall who they spoke with. Medical Doctor #1 stated they did not document the nurse's verbal report in the resident's medical record. Medical Doctor #1 stated they did not follow up with the Director of Nursing to ensure the issue was investigated. Medical Doctor #1 stated they did not know the Dietician recommended for a Speech Therapy evaluation or that Resident #271 requested downgraded diet consistency due to difficulty swallowing on [DATE]. 10 NYCRR 415.12(h)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255 Based on observation, record review and interview during the recertification survey from 12/11/24 to 12/18/2024, the facility did not ensure each resident received necessary respiratory care in accordance with professional standards of practice and as ordered by the practitioner for 3 (Resident #168, Resident #194, and Resident #69) of 6 residents reviewed for respiratory care. Specifically, 1) Resident #168 was observed tracheostomy self-suctioning without a physician order, 2) Resident #194 with a physician order for 3 and/or 5 liters of continuous oxygen was observed receiving 7 and/or 8 liters of oxygen and 3) for Resident #69 there was no documented evidence to indicate the oxygen tubing/cannula were being changed. The findings are: The policy and procedure titled Oxygen Administration with a 5/2024 revision date documented, the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure, oxygen therapy is administered by way of oxygen mask, non-rebreather oxygen mask, nasal cannula. equipment and supplies will be necessary when performing the procedure - oxygen concentrator, nasal cannula. Oxygen tubing will be changed as ordered and as needed and tubing will be dated to indicate last date of tubing change. 1) Resident #168 was admitted to the facility with diagnoses including but not limited to respiratory failure, schizophrenia, and bipolar disorder. The Physician Order documented 8/21/24 tracheostomy care every shift, and 10/24/24 oxygen via tracheostomy mask continuous 2-3 Liters/minute. There was no documented physician order for Resident #168 to self-suction their tracheostomy. The Quarterly Minimum Data Set (resident assessment tool) dated 11/7/24 documented, Resident # 168 was cognitively intact, had a tracheostomy and received oxygen therapy. The December 2024 Treatment Administration Record documented suction tracheostomy as needed and was not signed off by staff as completed. There was no documented evidence in Nursing and Respiratory Therapy Progress Notes that Resident # 168 was evaluated for ability to perform tracheostomy self-suctioning. During an observation on 12/12/24 at 9:53 AM Resident # 168 was resting in bed with 2 Liters of oxygen via tracheostomy mask. Resident #168 pulled the suction catheter, which was hanging freely without a cover, inserted the suction catheter to the tracheostomy site and performed self-suctioning. After completion of self-suctioning, Resident #168 placed the suction catheter over the nightstand. Resident #168 stated prior to facility admission they knew how to suction their tracheostomy. They stated after they were admitted a respiratory therapist observed and approved their self-suctioning. Resident #168 stated they could not remember the name of the therapist. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/13/24 at 3:39 PM Registered Nurse #6 stated only nurses performed tracheostomy suctioning. They stated respiratory therapy assessed the residents monthly. Registered Nurse #6 stated some time ago they observed Resident #168 performing tracheostomy suctioning, but they could not remember exactly when. Registered Nurse #6 stated they told the resident they were not allowed to perform self-suctioning, and reported this to Respiratory Therapy. Registered Nurse #6 stated they documented the situation but were unable to find the documentation. During an interview on 12/16/24 at 10:52 AM, the Director of Nursing stated they did not know of any residents who could perform tracheostomy self-suctioning, and staff had not reported Resident #168 was self suctioning. 2) Resident #194 was admitted to the facility with diagnoses including but not limited to respiratory failure, cerebrovascular accident, quadriplegia. The Quarterly Minimum Data Set, dated dated dated [DATE] documented, Resident # 194 had severe cognitive impairment, a tracheostomy and received oxygen therapy. The Physician Order dated 12/9/24 and December 2024 Medication Administration Record documented oxygen 3 liters continuous via tracheostomy. During observation on 12/13/24 at 3:16 PM, Resident #194 was in the bed receiving oxygen 8 liters via tracheostomy. The Medical Administration Record was signed by Registered Nurse #16 on 12/13/24 for administration of oxygen continuous via tracheostomy at 3 Liters. The Physician Order dated 12/16/24 and December 2024 Medication Administration Record documented continuous oxygen via tracheostomy mask at 5 liters/minute. During observation on 12/18/24 at 10:29 AM Resident #194 was in the bed, receiving oxygen 7 liters via tracheostomy. Registered Nurse Unit Manager #6 looked at the oxygen concentrator display and stated the oxygen concentrator was delivering 7 liters of oxygen. They stated this oxygen flow was incorrect and should have been delivered at 5 liters. They stated they did not know why the oxygen flow rate was administered incorrectly. 50816 3) Resident #69 had diagnoses including chronic obstructive pulmonary disease, encephalopathy, and acute kidney failure. The Minimum Data Set, dated dated dated [DATE] documented Resident #69 had severely impaired cognitive skills, shortness of breath when lying flat, and was on continuous oxygen therapy. The Physician's Order dated 11/22/2024 documented continuous 2 Liters of oxygen every shift for chronic obstructive pulmonary disease. The Physician's order dated 12/13/2024 documented change oxygen device nasal cannula every 7 days and as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan dated 11/24/2024 documented the resident had oxygen therapy related to respiratory illness, administer oxygen continuously by mask/cannula at 3 Liters per minute, There was no intervention to change the tubing. During observations on 12/12/24 at 9:02 AM and on 12/13/2024 at 12:37 PM, Resident # 69 was observed in bed, asleep with oxygen via nasal cannula. The nasal cannula oxygen tubing had no date. During an interview and observation on 12/13/24 at 3:43 PM Registered Nurse #7 stated the resident was on continuous oxygen. Registered Nurse #7 stated the facility protocol on oxygen therapy consisted of checking the order every shift and changing/labeling the cannula every 3 days by the night shift. Registered Nurse #7 observed the nasal cannula tubing and stated the tubing was not dated. Registered Nurse #7 further stated they had no idea when the oxygen tubing was last changed as it was not dated. 10 NYCRR 415.12(k) (6)

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

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on interview and record review conducted during the recertification and abbreviated (NY 00348067) survey from 12/11/2024 to 12/18/2024, the facility did not ensure the physician reviewed the resident's total program of care, including medications and treatments, at each visit. This was evident for 1 (Resident #271) of 6 residents reviewed for Accidents. Specifically, Medical Doctor #1 did not review and document a hospital Speech Pathology dysphagia diagnosis and diet texture recommendations for Resident #271 and did not review a Dietician note documenting Resident #271 had difficulty eating a regular texture diet. The findings are: The facility policy titled Aspiration Precaution dated 5/2024 documented the interdisciplinary team will collaborate and develop a personalized care plan documenting the resident's dietary recommendations and supervision needs. Resident #271 had diagnoses of cerebral infarction with left hemiplegia and hemiparesis, aphasia, and dysarthria. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #271 had mild cognitive impairments, required setup assistance with eating, did not receive speech therapy services, did not receive a mechanically altered diet, and did not display symptoms of a swallowing disorder. The Hospital After Visit Summary dated 3/25/2024 documented Resident #271 had a speech language pathology clinical swallowing evaluation on 3/18/2024. The evaluation documented Resident #271 had a past medical history of pneumonitis due to inhalation of food and vomit and dysphagia. The swallowing recommendations were for Resident #271 to receive a soft, bite-sized diet texture, mildly thick liquids with no straw, and intermittent supervision to monitor for aspiration. Physician Orders dated 3/25/2024 documented Resident #271 was ordered to be placed on aspiration precaution and receive a regular texture diet with thin liquids. The Admission Medical Evaluation dated 3/26/2024 documented Resident #271 had medically complex conditions and slurred speech. The Evaluations did not document Resident #271's history of dysphagia and diet recommendations from the hospital. A Dietary Note dated 6/28/2024 documented Resident #271 verbalized experiencing difficulty with chewing chicken and beef as well as coughing when drinking thin liquids. Resident #271 requested chopped texture protein, mashed potato instead of rice, and nectar thick liquids. The registered nurse supervisor and director of rehabilitation were made aware. The Medical Doctor Note dated 6/29/2024 documented Resident #271 was assessed for loose bowel movements. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order dated 7/2/2024 documented Resident #271's diet order was changed to regular texture with honey consistency liquids. There was no documented evidence the Medical Doctor reviewed and addressed Resident #271's total plan of care at each visit to address their diagnosis of dysphagia and difficulty chewing. On 12/18/2024 at 1:18 PM, Medical Doctor #1 was interviewed and stated they were Resident #271's attending physician and did not know the Dietician recommended for a Speech Therapy evaluation or that Resident #271 requested downgraded diet consistency due to difficulty swallowing on 6/28/2024. Medical Doctor #1 stated they only reviewed hospital discharge paperwork in relation to medication orders and did not pay attention to nutrition/diet orders. Medical Doctor #1 stated they did not review the Dietician's notes and relied on the nurse to provide them with the necessary information to determine resident treatment plans. On 12/18/2024 at 3:26 PM, the Medical Director was interviewed and stated they follow up with Medical Doctors almost daily. Medical Doctor #1 should have reviewed the Resident #271's medical record when assessing the resident and should have taken nutrition and Dietician notes into account when evaluating and determining the resident's plan of care. 10 NYCRR 415.15(b)(2)(iii)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50766 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00356093) surveys from 12/11/2024 to 12/18/2024, the facility did not ensure an effective pest control program was maintained to ensure the facility was free of pests. This was evident for 3 (2nd, 4th, and 6th Floors) of 5 resident floors reviewed for environment. Specifically, a 2nd floor Resident reported seeing roaches in their room, and roaches were observed on the 4th and 6th Floors. The findings are: The facility policy titled Pest Control dated 6/2024 documented a written agreement with a qualified outside pest service will be maintained to provide comprehensive pest control services utilizing a variety of methods to eradicate and contain household pests, including roaches. There was no documented evidence of a valid Pest Management Contract. The Facility Survey Report and the Facility Assessment, both dated 12/11/2024, did not identify a third-party contractual agreement with a pest control company and did not document pest control as a necessary service to care for residents. During an interview on 12/12/2024 at 12:06 PM, Resident #182 stated there were roaches in their room and bathroom on the 2nd Floor. The resident's representative bought and placed roach traps in the room to address the issue. On 12/12/2024 at 12:35 PM, Resident #152 stated there was a persistent and pervasive roach infestation in their room. The roaches were visible at all times of the day, but the activity worsened at night when the roaches crawled up their privacy curtain and along the walls next to their bed. Resident #152 stated they kept a blue latex glove at their bedside to smash the roaches that crawled near them at night. Resident #152 stated their bedside dresser was overrun with roaches even though they did not keep any food items in their room. Resident #152 stated they had reported the issue to the nursing staff and observed an exterminator come into the room several weeks ago, but the roach activity did not decrease. During the interview, Resident #152's beside dresser was observed without clutter or food items. A large roach quickly darted out of the opened middle drawer, ran down the exterior and disappeared under the dresser. A medium-sized roach was also observed crawling inside the top drawer near the resident's wash basin. Several small roaches were observed on the floor under Resident #152's bed and near the bedside table. The wall near the window in Resident #152's room was observed with a crushed roach approximately 4 feet off the floor. During an interview with Certified Nurse Aide #18 on 12/13/2024 at 02:32 PM in room [ROOM NUMBER], A medium-sized roach was observed crawling on the floor. Certified Nurse Aide #18 killed the roach by stepping on it and stated they previously observed roaches on the 4th Floor, reported the sightings by documenting in the unit's Pest Logbook, and saw an exterminator come to treat the unit. The Pest Logbook for 2nd, 4th, and 6th Floors, reviewed from 12/1/2023 to 12/11/2024, documented there were roaches in all rooms on the 4th Floor. Roach observations were not documented on the 2nd Floor or Resident #152's room on the 6th Floor. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence the facility requested or received recommendations and alternative treatment options from the Pest Management Company for continued roach infestations in the facility. During an interview on 12/17/2024 at 08:48 AM, Certified Nurse Aide #31, assigned to the 2nd Floor, stated there was a significant roach problem in resident rooms, hallways, and dining room. Certified Nurse Aide #31 stated they observed roaches daily and reported their observations to the floor Nurse Manager. Certified Nurse Aide #31 stated they previously saw an exterminator visit the facility but was unable to state how often pest control services were provided to the unit. They stated housekeeping cleaned resident room's daily but sometimes there was 1 Housekeeper for the entire unit. During an interview on 12/17/2024 at 09:13 AM, Housekeeper #32, assigned to the 2nd Floor, stated they observed roaches on the 2nd Floor and throughout the rest of the facility. The roach infestation was difficult to control because some residents kept food in their rooms. Housekeeper #32 stated an exterminator visited the facility and recently there was less roach activity. During an interview on 12/17/2024 at 09:24 AM, Registered Nurse #30, 2nd Floor Nurse Manager, stated they observed roaches in the hallways and nursing station on when working overnight. They stated they documented their observation in the Pest Logbook and the exterminator visited the facility weekly. During an interview on 12/17/2024 at 01:10 PM, the Director of Housekeeping stated the facility worked with a Pest Management Company and an exterminator visited the facility weekly. Reports of pest concerns and observations were documented in the Pest Logbooks on each floor. The Director of Housekeeping met with the exterminator at the conclusion of each facility visit and received a verbal report of the exterminator's activities and recommendations. The Director of Housekeeping stated they met with the Administrator to update them verbally on the exterminator recommendations. Their most recent pest control discussion with Administration took place in 11/2024 and involved terminally cleaning 1 resident room (including dresser drawers, and closets) per day. Housekeeping staff completed a Terminal Cleaning Log for each room they completed. The roach infestation was difficult to control because residents kept food in their rooms and there was ongoing construction in the facility. The Director of Housekeeping was unable to provide documented evidence the Terminal Cleaning Logbook addressed pest infestation concerns, of exterminator meetings and recommendations, and that meetings with Administration took place to review and address exterminator recommendations regarding roach infestation. During an interview on 12/18/2024 at 05:51 PM, the Administrator stated the Pest Management Company treated resident rooms, bombing them, if necessary, when staff identified sightings of pests. Housekeeping staff conducted terminal cleaning of the rooms. Staff educated residents to address behaviors that may contribute to roach infestation. The Administrator stated they conducted visual rounds of resident floors daily and recorded their observations of pests in the Pest Logbook. Housekeeping coordinated with the Pest Management Company and followed up on verbal recommendations. The Administrator stated there was no documented evidence the Pest Management Company provided the facility with recommendations to abate roach infestation or that the facility addressed verbal recommendations with an action plan. 10 NYCRR 415.29(j)(5) (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40686 49255