

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/25/2025
NAME OF PROVIDER OR SUPPLIER  Hudson Hill Center for Rehabilitation & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review and interviews during an abbreviated survey (NY00372408), the facility did not ensure that all alleged violations are thoroughly investigated for 1 of 3 residents (Resident #1) reviewed for accidents. Specifically, on 1/5/2025 Resident #1 obtained hot liquid from the hot liquid cart on the unit and carried the hot liquid to another resident's room unwitnessed/undetected by staff. Resident #1 immersed their feet in the hot liquid for 25 to 30 minutes and sustained second and third- degree burns to both feet. The accident/incident report documentation was noted to be inconsistent with the summary of events reported by Resident #1 and the witnesses to the incident on 1/5/2025. Additionally there was no documented evidence of statements from Certified Nurse Aide #1 and Resident #2, who were witnesses to the incident that occurred on 1/5/2025.</p> <p>The Findings are:</p> <p>The Facility undated Accidents and Incidents-Investigating and Reporting policy documented the following data as applicable, shall be included on the Report of Incident/Accident form: the date and time the accident or incident took place, where the accident or incident took place, the names of witnesses and their accounts of the accident or incident, the injured persons account of the accident or incident any corrective action taken.</p> <p>Resident #1 was admitted with diagnoses including but not limited to Diabetes Mellitus, Peripheral Vascular Disease and Polyneuropathy.</p> <p>A Quarterly Minimum Data Set (an assessment that measures health status) dated 11/17/2024 documented the resident was cognitively intact with no behaviors. Resident #1 had no impairments to their upper and lower extremities and used a walker for locomotion. Resident #1 required set up assistance with eating, supervision with toileting, bed mobility, transfers and ambulation. Resident #1 had an infection of their foot and was receiving surgical wound care with the application of dressings to their feet.</p> <p>Review of an accident/incident report dated 1/5/2025 revealed no documented evidence of a statement being obtained from the witnesses (Certified Nurse Assistant #1 and Resident #2) about the incident that occurred on 1/5/2025.</p> <p>(continued on next page)</p>		

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/19/2025 at 1:30 PM, Certified Nurse Aide #1 stated during the evening shift on 1/5/2025, they saw Resident #1 in the room sitting in the chair with their feet soaking in water. Certified Nurse Aide #1 stated when Resident #1 saw them the resident stated they had soaked their feet in hot water, and they were popping. Certified Nurse Aide #1 stated they told Resident #1 they are not supposed to soak their feet in hot water because they are Diabetic, and they may not feel if they are getting burned. Certified Nurse Aide #1 stated Resident #1 took their feet out of the water, and they saw blisters on residents' feet. Certified Nurse Aide #1 stated Resident #1 then stated they were in pain and could not walk. Certified Nurse Assistant #1 stated they went and reported this to Licensed Practical Nurse #1 who was assigned to Resident #1. By the time they got to the nurse at the nurse's station, Resident #1 was seen walking towards them. Certified Nurse Aide #1 stated at that time Registered Nurse #2 was in the office not far from the nurse's station and the nurse told Registered Nurse #2 (the supervisor). Resident #1 went to the nursing office with the Registered Nurse #2(the supervisor). Certified Nurse Aide #1 stated they do not know where Resident #1 got the water. The resident had their feet in the basin of water when they saw the resident. Certified Nurse Aide #1 stated there were blisters to Resident #1's feet when they took their feet out of the water. Certified Nurse Aide #1 stated they were not asked to write a statement about the incident which occurred on 1/5/2025.</p> <p>During an interview on 2/19/2025 at 2:29 PM, Registered Nurse #2 stated on 1/5/2025 Licensed Practical Nurse #1 approached them and asked them to assist with Resident #1. Registered Nurse #2 stated they were told at 10:00 PM that Resident #1, at 7:00 PM during dinner, had washed their feet with water from the coffee pot. Registered Nurse #2 stated Licensed Practical Nurse #1 stated they were just informed about the incident at 10:00 PM by Certified Nurse Aide #1. Registered Nurse #2 stated Certified Nurse Aide #1 had reported to Licensed Practical Nurse #1 that they saw Resident #1 soak their feet in warm water. Registered Nurse #2 stated they were not sure how Resident #1 got enough hot water to fill a basin, but the certified nurse aides may have been busy. Registered Nurse #2 stated they were told by Licensed Practical Nurse #1 that the incident occurred in Resident #1's room. Registered Nurse #2 stated they were not informed by any staff that they saw Resident #1 getting the hot water and the hot liquid kettle has a faucet drain which would take about 20 minutes to fill a bucket. Registered Nurse #2 stated they did not obtain a statement from Certified Nurse Assistant #1 or Resident #2(witnesses to the incident), but they took a statement from the certified nurse aide assigned to Resident #1.</p> <p>During an interview on 2/20/2025 at 10:38 AM, Resident #2 stated Resident #1 came into their room to wash their feet in some warm water. Resident #2 stated they assumed Resident #1 got the water to wash their feet from where they get their water for coffee and tea by the dining room. Resident #2 stated the water in the sink is never warm enough. This was the first time they know of that Resident #1 got water from the kettle. Resident #2 stated Resident #1's feet were very dark, so they felt they were dirty and said they were going to clean their feet by themselves. Resident #2 stated Resident #1 then put their feet in the water and their feet started to bubble and blister up. Resident #2 stated the hot liquid cart is kept right outside the dining room and is always accessible to the residents on the units.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/20/2025 at 11:35 AM, the Director of Nursing stated the investigation report along with statements are collected the same day an incident occurs. The designee reviews the incident and follows up to ensure everything was completed for the incident report. Once they have everything the investigation is completed with a conclusion. the Director of Nursing stated the Assistant Director of Nursing is the one who is the facility designee who reviews the incident reports. The designee ensures the care plan is revised and everything outstanding such as x ray test/results are completed. The role of the Certified Nursing Aides is to fact check. Director of Nursing acknowledged that moving forward they should date the conclusion of their investigative summary.</p> <p>During an interview on 2/20/2025 at 11:50 AM, the Assistant Director of Nursing #1 stated the investigative conclusion summary occurred after the incident. The surveyor pointed out the undated investigative conclusion summary then the Assistant Director of Nursing #1 stated they were not sure of the exact date they arrive at the conclusion of the incident with Resident #1 that occurred on 1/5/2025. The Assistant Director of Nursing #1 acknowledged they do not date the investigative summary conclusions, but moving forward they will date the investigative summary conclusion. The Assistant Director of Nursing #1 stated they conducted a fact check of the incident by speaking to Resident # 1 several times, the nursing supervisor, the nurse on the unit and the certified nurse aide who was assigned to Resident #1. The Assistant Director of Nursing #1 stated they completed a look back and found that Resident # 1 had a small blister on 1/4/2025 and reviewed progress notes on how it was being treated. The Assistant Director of Nursing #1 stated Resident # 1 was crying and stated to them that they snuck out and got the water. The Assistant Director of Nursing #1 stated when they interviewed Resident # 1, the resident stated they soaked their feet in Resident #2's room not in their own room.</p> <p>During an interview on 2/20/2025 at 4:09 PM, the Administrator stated if a resident is alert then they are asked to provide an account of whatever the incident maybe. If the incident is not witnessed.the staff who witnessed the incident will be interviewed. The Administrator stated if the incident is unwitnessed, and no one can account for what occurred then they interview everyone to try and understand what happened. The Administrator stated these interviews are run by the nursing management team and they are kept abreast of what is going on with the investigation.</p> <p>10 NYCRR 415.4 (b)(1)(ii)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during an abbreviated survey (NY00372408) the facility failed to ensure the resident environment remains free of accident hazards as is possible and each resident receives adequate supervision to prevent accidents for one (1) of three (3) residents (Resident #1) reviewed for safety and supervision. Specifically, on 1/5/2025, Resident #1 obtained hot water from the hot liquid cart, filled their basin and carried it to a room and immersed their feet without the knowledge or detection of unit staff. Resident #1 was found with blisters to bilateral feet and sustained second- and third-degree burns. On 1/15/2025, Resident #1 was transferred to the hospital with a fever and for burn evaluation. On admission to the hospital, Resident #1 was determined to have third degree burns and underwent a skin graft on 1/21/2025. There was no facility policy that addressed the monitoring of hot water carts when they are on the resident units. Furthermore, the monitoring of the hot water cart was sporadic and arranged by word of mouth and monitoring was not consistently in place for the period when the hot water carts are on the units. This resulted in actual harm for Resident #1 which was Immediate Jeopardy with the likelihood of risk for harm to the health and safety of other residents.</p> <p>The Findings are:</p> <p>Review of the facility Hot Liquids Safety Policy last reviewed 6/20/2024 documented hot liquids are to be served at proper (safe and appetizing) temperatures using appropriate safety precautions. The temperature of hot liquids will be checked in the dietary department prior to distribution to the nursing units. If the temperature is greater than 140 degrees Fahrenheit, hold the liquid in the dietary department until it reaches appropriate temperature. General safety precautions when serving hot liquids include but are not limited to regulate temperature of hot liquids to which residents have direct access.</p> <p>Resident #1 was admitted with diagnoses including but not limited to diabetes mellitus, peripheral vascular disease, polyneuropathy (a condition that damages multiple peripheral nerves affecting sensation, movement or both).</p> <p>A Quarterly Minimum Data Set (an assessment that measures health status) dated 11/17/2024 documented the resident was cognitively intact with no behaviors noted. Resident #1 used a walker for locomotion and had no impairments to their upper and lower extremities. Resident #1 required set-up assistance with eating and supervision with toileting, bed mobility, transfers, and ambulation. Resident #1 had an infection of their foot and was receiving surgical wound care with the application of dressings to their feet.</p> <p>Review of a diabetes mellitus care plan initiated 4/13/2024 documented the following interventions: avoid exposure to extreme heat and cold, assess feet daily for any open areas, sores, pressure areas, blisters or redness and monitor/document/report as needed any signs and symptoms of infection to any open areas.</p> <p>Review of an activities of daily living care plan initiated 10/15/2024 and revised on 2/15/2025 with no changes documented Resident #1 was dependent on staff daily for meeting activity of daily living needs. The resident required set-up assistance with eating, supervision with showering/bathing, and putting on and removing their shoes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Facility Summary of Investigation dated 1/5/2025 documented Registered Nurse Supervisor #1 was summoned to see Resident #1 for the presence of blisters to bilateral (both) feet. Resident #1 was noted with fluid filled blisters on dorsal (top) aspect of bilateral feet. On interview, the resident admitted they sneaked out to get water from the tea cart without anybody seeing to intentionally wash their feet with the warm water; I soaked my feet in the water for about 30 minutes in another resident's room. I didn't feel anything, but it felt weird because my feet turned white, so I reported it to the nurse. Medical Doctor was notified and ordered treatment with a topical antimicrobial cream every shift for five (5) days and to monitor site for symptoms of infection. Family notified and agreed with plan of care.</p> <p>Review of the coffee and hot water temperature chart for January 2025 documented the following temperatures: January 4, 2025 4:45 PM 119 degrees Fahrenheit; January 5, 2025, 4:45 PM 122 degrees Fahrenheit.</p> <p>Review of an accident/incident report dated 1/5/2025 documented Resident #1 was assessed for a change in skin condition by Registered Nurse #2 at 10:00 PM. The accident/incident was reported by Licensed Practical Nurse #1 on 1/5/2025 at 10:00 PM. Resident #1 was ambulatory and the incident occurred in the resident's room. The Attending Physician was notified on 1/5/2025 at 10:02 PM and Resident #1's representative was notified on 1/5/2025 at 10:05 PM. Actions taken to prevent recurrence included educating Resident #1 to not poke the blisters, and how to properly care for the blisters.</p> <p>Review of Registered Nurse #2's incident note dated 1/5/2025 at 10:00 PM documented they were called to assess Resident #1 regarding the presence of blisters to bilateral feet which started from a small blister on 1/4/2025. Resident #1 reported on interview that they washed their feet with warm water during dinner time. On assessment, Resident #1 was noted with fluid-filled blisters on bilateral dorsal feet. No redness was noted between Resident #1's toes. The Attending Physician was notified and ordered to start a topical antimicrobial cream for five (5) days to bilateral feet blisters. Resident #1 was to be monitored for signs of infection and their family made aware.</p> <p>Review of a Nurse Practitioner #1 medical progress note dated 1/6/2025 at 2:01 PM documented they were asked to see Resident #1 for burns on both feet. Resident #1 was noted to have huge blisters covering both feet. As per Resident #1, they soaked their feet in hot water yesterday from their tea container. Documentation revealed Resident #1 has no feeling in their feet due to neuropathy and did not notice that their feet got burned. Safety was reinforced with Resident #1 and communicated with nursing staff and administration regarding Resident #1's access to hot water. The Assessment/Plan documented second degree burn, do not pop blisters, continue to monitor, reinforce safety with Resident #1, if blisters pop, apply a topical antimicrobial cream two (2) times daily and schedule wound consult.</p> <p>Review of the Attending Physicians medical visit note dated 1/8/2025 at 3:49 PM documented Resident #1 was seen for follow-up regarding second degree burns on bilateral feet. Resident #1 was noted to have huge blisters popped up on both feet, wound treatment applied. Safety was reinforced with Resident #1. The Attending Physician documented they communicated with nursing staff and Administration regarding Resident #1's access to hot water and resident's safety. The assessment/plan documented second degree burns-do not pop blisters, continue to monitor, reinforce safety to resident. The Plan continued: Resident #1's blisters are popped at this time, no need for antibiotic but will continue antibiotic skin cream or topical antimicrobial cream to sites.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of an actual skin impairment care plan initiated 1/5/2025 documented Resident #1 had skin impairment to their bilateral dorsal feet related to burns. Interventions listed included follow facility protocols for treatment of injury and identify/document and eliminate/resolve where possible.</p> <p>Review of wound care notes dated 1/10/2025 documented Wound 1 with date of onset 1/5/25, etiology: 3rd degree burns on right dorsal foot measuring length: 9.0 centimeters width: 18.0 centimeters Depth: 0.1 centimeters. wound bed: 100% collapsed blister, scant exudate (drainage) with no odor. Recommended primary dressing of Xeroform + Calcium alginate + gauze + Kerlix daily and as needed</p> <p>Wound 2 with onset date 1/5/2025, etiology: 3rd degree burns of right plantar foot measuring: length: 5.0 centimeters width: 6.0 centimeters depth: 0.1 centimeters, wound bed: 100% collapsed blister and scant exudate with no odor. Recommendation for primary dressing to apply Xeroform + Calcium alginate + gauze + Kerlix daily and as needed.</p> <p>Wound 3 with onset date 5/2025, etiology: 3rd degree burns of left foot measuring: length: 9.0 centimeters with width: 18.0 centimeters and depth: 0.1 centimeters. Wound Bed is 100% collapsed blister. Moisture with scant exudate, serous (yellowish colored drainage) with no odor. Recommended primary dressing of Xeroform + Calcium alginate + gauze + Kerlix daily and as needed</p> <p>There is no documented evidence of the wound progression.</p> <p>Resident #1 was discharged to the hospital on 1/15/2025 for fever and evaluation of burns.</p> <p>Resident #1 was admitted to the hospital with second- and third-degree scald burns to bilateral feet with cellulitis. Resident #1 had a surgical technique where a surgeon removes burned or damaged skin layer by layer until they reach healthy tissue, and then covers the resulting wound with a thin layer of skin taken from another part of the body (split thickness skin graft) to the left foot and application of a mesh structure to help cells attach to the right foot on 1/21/2025 during the admission. Hospital discharge notes documented Resident #1 returned to the facility on 2/3/2025</p> <p>On 2/10/2025 following an out-patient burn clinic post-operative follow-up appointment, it was decided Resident #1 needed to be admitted back to the hospital for possible wound infection.</p> <p>Review of hospital Discharge summary dated [DATE] documented Resident #1 had failure of skin graft and cellulitis of the fifth toe on the left foot. Resident #1 was treated for wound management, intravenous antibiotics, and pain control.</p> <p>During an interview on 2/19/2025 at 12:32 AM, Resident #1 stated they went to the tea kettle that came to the unit with the meal truck for tea or coffee. Resident #1 stated they filled up their basin with the hot water from the tea kettle and went to Resident #2's room. Certified Nurse Assistant #1 asked what they were doing, and they told Certified Nurse Assistant #1 they were soaking their feet. Resident #1 stated they put their feet in the water for 25 to 30 minutes and did not feel anything because they have had neuropathy for the last 19 years. Resident #1 stated when they removed their feet from the basin their feet were two big bubbles. Resident #1 stated they did not check the temperature of the water. Resident #1 stated they figured the water was hot or warm but did not know that it was scalding.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/19/2025 at 1:30 PM, Certified Nurse Assistant #1 stated during the evening shift on 1/5/2025 they went to give care to a resident in room [ROOM NUMBER]. Resident #1 usually goes to room [ROOM NUMBER] because they know the residents in that room. Certified Nurse Assistant #1 stated they saw Resident #1 in the room sitting in the chair with their feet soaking in water. Certified Nurse Assistant #1 stated when Resident #1 saw them they stated they had soaked their feet in hot water, and they are popping. Certified Nurse Assistant #1 stated they told Resident #1 they are not supposed to do that because they are diabetic, and they may not feel if they are getting burned. Certified Nurse Assistant #1 stated Resident #1 then took their feet out of the water, and they saw blisters on their feet. Certified Nurse Assistant #1 stated Resident #1 then stated they were in pain and could not walk. Certified Nurse Assistant #1 stated they do not know where Resident #1 got the water, and the resident already had their feet in the bucket of water when they saw them. Certified Nurse Assistant #1 stated they saw blisters to Resident #1's feet when they removed their feet from the water and reported it to Licensed Practical Nurse #1.</p> <p>During interview on 2/19/2025 at 1:56 PM, Registered Nurse #1 stated the hot liquid cart comes up with each meal. The residents know not to touch this cart. Registered Nurse #1 stated the incident happened on the weekend, so they are not sure why no staff saw Resident #1 getting the water from the hot liquid cart. Registered Nurse #1 stated they have now instituted that on the day and evening shift a nurse or certified nurse assistant remains in the area by the hot liquid cart. Registered Nurse #1 stated the hot water cart is now out of the dining room and is monitored. Registered Nurse #1 stated the nurses on the west side are responsible to be in the dining room when the trucks arrive to the unit and if there are residents in the dining room, a nurse needs to remain in the dining room.</p> <p>During an interview on 2/19/2025 at 2:29 PM, Registered Nurse #2 stated they are not sure how Resident #1 got enough hot water to fill a basin. The certified nurse assistants may have been busy. Registered Nurse #2 stated they were approached by Licensed Practical Nurse #1 who asked them to assist with Resident #1. Registered Nurse #2 stated they were told at 10:00 PM that Resident #1, at 7:00 PM during dinner, had washed their feet with the water from the hot liquid cart. Registered Nurse #2 stated Licensed Practical Nurse #1 stated they were just informed about the incident at 10:00 PM by Certified Nurse Assistant #1. Registered Nurse #2 stated Certified Nurse Assistant #1 had reported to Licensed Practical Nurse #1 that they saw Resident #1 soak their feet with warm water. Registered Nurse #2 stated Licensed Practical Nurse #1 was the medication nurse for Resident #1 at the time of the incident. Registered Nurse #2 stated they were not informed by any staff that they saw Resident #1 getting the hot water. The kettle for tea on the hot liquid cart has a faucet drain and it would take about 20 minutes to fill a bucket. Registered Nurse #2 stated after the incident occurred there is now one certified nurse assistant assigned to stay by the hot liquid cart and they also spoke with dietary to ensure the water brought to the units is warm and not scalding hot anymore. Registered Nurse #2 stated there is an assignment sheet now to monitor the hot liquid cart.</p> <p>During an interview on 2/19/2024 at 3:11 PM, the Director of Nursing stated after the incident on 1/5/2025 they provided an in-service to the staff. The facility now designates an aide to be to be near the hot water cart but there is no sign-in sheet. They have one (1) nurse always assigned to the dining room. Director of Nursing stated they are not aware of a policy change since the incident. It is possible the facility could have updated a policy without them being aware, since they were out for one (1) month.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/19/2025 at 4:02 PM, Dietary Supervisor Weekends stated the hot liquid carts are picked up from the unit about 45 minutes to an hour after meals are served. The Dietary Supervisor Weekends stated the hot liquids are left outside of the dining room by the dietary staff when delivered to the units. Dinner begins at 4:45 PM and is supposed to end at 5:45 PM, but sometimes it ends at 6:10 PM. The Dietary Supervisor Weekends stated it will be unusual for the hot liquid truck to be on a unit at 7:00 PM. The Dietary Supervisor Weekends stated in January the facility only had one (1) elevator in service, so it may have been possible for the hot liquid truck to be on the unit until 7:00 PM. The Dietary Supervisor Weekends stated they were not informed of any changes to the policy regarding hot liquids.</p> <p>During an interview on 2/20/2025 at 10:38 AM, Resident #2 stated Resident #1 came into their room to wash their feet in some warm water. Resident #2 stated they assumed Resident #1 got the water to wash their feet from where they get the water for coffee and tea by the dining room. Resident #2 stated the water in the sink is never warm enough, and this was the first time they've known Resident #1 to get the water from the kettle. Resident #2 stated Resident #1's feet were very dark, so they felt they were dirty and said they were going to clean their feet themselves. Resident #2 stated Resident #1 then put their feet in the water and their feet started to bubble and blister up. Resident #2 stated the hot liquid cart is kept right outside the dining room on the unit and is always accessible to the residents.</p> <p>During a telephone interview on 2/20/2025 at 2:11 PM, the Attending Physician stated they have serviced the facility for three (3) years now. The Attending Physician stated they were informed by Registered Nurse #2 on 1/5/2025 that Resident #1 got hot water from the hot liquid cart, and it dropped on their foot and had sustained blisters on both feet. The Attending Physician stated they instructed Registered Nurse #2 to apply ointment to Resident #1's feet and they saw and evaluated Resident #1 the next day. The Attending Physician stated after they saw Resident #1's feet they instructed the resident and the nurses not to pop the blisters, because if they are not popped there will be no infection. The Attending Physician stated they did not order a wound care consult at that time because the blisters were intact. The resident was already on pain medication and their pain has been managed therefore no additional pain medications were ordered. The Attending Physician stated they and the Nurse Practitioner saw Resident #1 again when the blisters were popped, and a wound care consult was ordered at that time. The Attending Physician stated after the burns occurred, they saw Resident #1 within the next 2-3 days after the incident and they were alternating with the Nurse Practitioner making visits to see the resident. The Attending Physician stated they do not believe that the blisters Resident #1 sustained were from submerging their feet in hot water. Resident #1 sustained blisters only to the dorsum of their feet. The Attending Physician stated when they evaluated Resident #1, they only saw the blisters on the top of their feet. The Attending Physician stated the plantar surface of the foot skin is thicker and would take longer to develop blisters. The Attending Physician stated they had a discussion with the Administrator regarding not having the hot liquid carts on the unit and limiting the residents access to the hot water and they stated they would take care of this no problem. The Attending Physician stated they were not sure if there is a policy about reporting these types of injuries like burns. Maybe the Medical Director might know. They will ask and find out if one exists.</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/20/2025 at 4:09 PM the Administrator stated they do not remember who informed them, but they were informed Resident #1 got a hold of some water somehow and had a blister on their foot. The Administrator stated they were further informed Resident #1 got the water from the hot liquid cart on the unit and instructed the staff to continue their investigation. The Administrator stated they were told Resident #1 called one of the staff to the room and informed them they got the hot water from the urn and put the water in a basin, placed their feet in the water and got a burn or blister or something like that. The Administrator stated they told the supervisor to treat Resident #1 and inform the physician. The Administrator stated they were not in the building when the incident occurred on 1/5/2025, but when they returned to the facility, they spoke about the details of the event in morning report and the investigation was taken over by the Assistant Director of Nursing. Since the incident, the steps they have implemented to prevent reoccurrence are they have a temperature log of when the hot liquid cart leaves the kitchen, the hot liquid cart are monitored by staff when they are in the dining room, and they have ongoing staff education on hot liquids.</p> <p>During an interview on 2/21/2025 at 1:15 PM the Director of Dietary Services stated the hot liquids get temperature tested, and they complete the testing three (3) times day as they are in the building for all three (3) meals throughout the day during the week. The Director of Dietary Services stated the hot liquids do not go to the units unless the temperature is between 115 and 125 degrees. The Director of Dietary Services stated most of the time the liquids are sent to the units at 120 degrees. The Director of Dietary Services stated the dietary aides place the hot liquid carts by the nurse's station when they deliver the truck to the units. The dietary aides do not leave the hot liquids on the unit until they locate a nurse to sign off on the delivery truck sheet. The Director of Dietary Services stated if a nurse is busy, a certified nurse assistant will assume the responsibility and sign for the carts.</p> <p>10 NYCRR 415.12(h)(1)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on record review and interviews during a partial extended survey, the facility administrator did not ensure they used its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, on 1/5/2025 a resident obtained hot water from the hot liquid cart and sustained second- and third-degree burns. The Administrator did not initiate any policy changes or protocol updates to prevent reoccurrence of such incidents or provide any documentation to support review of the incident details. In addition, the Administrator also did not provide any documented evidence of action plans or performance improvement plans implemented for identified areas of deficiencies discussed in Quality Assurance and Performance Improvement meetings held on 2/3/2025, 2/12/2025 and 2/27/2025.</p> <p>The findings are:</p> <p>The facility Quality and Performance Improvement policy dated documented the Quality Assurance and Improvement program includes the establishment of a Quality Assessment and Assurance committee and a written Quality Assurance and Performance Improvement plan. The Quality Assessment and Assurance committee shall be interdisciplinary and shall consist of a minimum of the Director of Nursing, Medical Director and at least three other members of the facility's staff, at least one of which must be the Administrator and the Infection Preventionist. The committee must meet at least quarterly and as needed to coordinate and evaluate activities under the Quality Assurance and Performance Improvement program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the Quality Assurance and Improvement program, as necessary. Develop and implement appropriate plans of action to correct identified quality deficiencies. Regularly review and analyze data, including data collected under the Quality Assurance and Performance Improvement program and act on available data to make improvements.</p> <p>The facility provided attendance sheet for Quality Assurance Performance Improvement meeting held on 2/3/2025 for Quality Assurance and Performance Improvement-complaints survey. However, there were no documented evidence of action plans or performance improvement plans implemented for any area of deficiencies identified.</p> <p>The facility provided attendance sheet for Quality Assurance Performance Improvement meeting held on 2/12/2025 for Quality Assurance and Performance Improvement -annual survey. However, there were no documented evidence of action plans or performance improvement plans implemented for any area of deficiencies identified.</p> <p>The facility provided attendance sheet for Quality Assurance Performance Improvement meetings held on 2/27/2025 for life safety quality assurance and performance improvement. However, there were no documented evidence of action plans or performance improvement plans implemented for any area of deficiencies identified.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/4/2025 at 11:39 AM, the Administrator stated they were not in the building when the incident occurred on 1/5/2025, but when they returned to the facility, they spoke about the details of the event in morning report and the investigation was taken over by the Assistant Director of Nursing. The Administrator stated the steps they have implemented to prevent reoccurrence of the incident are they have a temperature log of when the urn leaves the kitchen, the urns are monitored by staff when they are in the dining room and providing education on hot liquids which is ongoing. The Administrator stated the temperature log for the hot liquids is not new, but something they have been doing and there was no update to that policy. The Administrator stated they are not sure if a policy update was made regarding monitoring the urns on the unit and they would have to ask staff because they are not sure. The Administrator stated they would be a part of a policy change, but they just went through survey, and they are not sure if this was one that was reviewed. The Administrator stated they are not sure if they made any immediate changes to the hot liquid policy following the incident. The Administrator stated they are working on the plan of corrections from their recent survey, and they are basically copying and pasting the corrections.</p> <p>During an interview on 3/4/2025 at 12:27 PM, the Director of Nursing stated they oversee the Performance Improvement Plans for the Quality Assurance and Performance Improvement issues. The Director of Nursing stated the Quality Assurance meetings are held depending on the progress of the issue. The Director of Nursing stated each issue is addressed in the Quality Assurance meetings by team members, the members determine how long the issue will take to resolve and if another issue of the same kind comes up and they are approaching the finish of a problem, the team then pause the action plan and will revisit the issue. The Director of Nursing stated in morning report they discuss issues and Quality Assurance and Performance Improvement plans every Friday. The Director of Nursing stated Quality Assurance and Performance Improvement meetings-consist of the Director of Nursing, nurse managers, nursing supervisors and the Assistant Administrator. The Director of Nursing stated the Administrator is invited to the quarterly meetings, but they are not present for the meetings held on Fridays.</p> <p>10 NYCRR 415.26</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during a partial extended survey (NY00372408) the facility did not ensure the facility-wide assessment documented all personnel, including other direct care staff (both employees and those who provide services under contract), as well as their education and/or training and any competencies related to resident care. Specifically, the facility schedule revealed the use of patient care assistants in the facility to assist residents with grooming tasks and housekeeping tasks. Review of the facility assessment revealed the patient care assistants were not included in the individual staff assignments listed and there were also no competencies listed for the patient care assistants to describe their functions on the units. Furthermore, the training provided to the patient care assistants by the facility was not captured on the Facility Assessment.</p> <p>Findings include:</p> <p>A review of the Facility Assessment policy last revised 5/2024 documented the facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for our residents competently during both day-to-day operations, including nights and weekends, and emergencies. The purpose of this policy is to establish responsibilities and procedures for the facility assessment process. The facility assessment will at minimum address, and include: all personnel, including managers, nursing, and direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and or training and any competencies related to resident care.</p> <p>On 3/5/2025 the Surveyor requested a copy of the Facility Assessment; the facility provided a copy dated 2/3/2025 and reviewed by the Quality Assurance and Improvement committee on 2/27/2025.</p> <p>Review of the facility assessment dated [DATE] revealed the patient care assistants were not included in the individual staff assignments listed. There were also no competencies listed for the patient care assistants describing their functions on the units.</p> <p>There was no documented evidence in the Facility Assessment indicating a patient care assistant training was provided in the facility.</p> <p>A review of staffing schedules from 12/4/2024 to 2/28/2025 revealed patient care assistants were scheduled daily during the day shift on each unit.</p> <p>During a follow up interview on 3/4/2025 at 1:32 PM the Staffing Coordinator stated the patient care assistants were students trained by the facility. The Facility has a patient care assistant school on the premises. The Staffing Coordinator stated the patient care assistants assist the residents with grooming and housekeeping, but they do not perform any personal care. The Staffing Coordinator stated the patient care assistants are not included in the staffing numbers, but they are on the daily schedules.</p> <p>(continued on next page)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow up interview on 3/4/2025 at 4:50 PM the Administrator stated they were unaware that the patient care assistants and the patient care assistant school needed to be included in the Facility Assessment. The Administrator stated that they may no longer be able to run the patient care assistant school after the deficiencies received.</p> <p>10 NYCRR 415.26</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on record review and interviews conducted during a partial extended survey (NY00372408), the facility did not ensure the Quality Assurance and Performance Improvement (QAPI) committee developed and implemented appropriate plans of action to correct identified quality deficiencies. Specifically, on 1/5/2025 a resident obtained hot water from the hot liquid cart and sustained second- and third-degree burns. There were no documented evidence of any good faith attempts by the committee to identify and correct the deficiencies brought about by the 1/5/2025 incident.</p> <p>The findings are:</p> <p>The facility undated Quality Assurance and Improvement policy documented it is the policy of the facility to develop, implement, and maintain an effective, comprehensive, data-driven Quality Assurance and Improvement program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. The Quality Assurance and Improvement program includes the establishment of a Quality Assessment and Assurance committee and a written Quality Assurance and Improvement Plan. The Quality Assessment and Assurance shall be interdisciplinary and develop appropriate plans of action to correct identified quality deficiencies.</p> <p>Review of the Quality Assurance Performance Improvement meetings held on 2/3/2025, 2/12/2025, and 2/27/2025 revealed no documented evidence of any action plans or performance improvement plans specific to the incident on 01/05/2025.</p> <p>During an interview on 3/4/2025 at 11:39 AM, the Administrator stated the Quality Assurance and Performance Improvement meeting are held quarterly. The Administrator stated whenever a survey occurs, and a citation is issued they have a Quality Assurance and Performance Improvement meeting for the issues. The Administrator stated the Quality Assurance and Performance and Improvement committee consists of all department heads, unit managers, Medical Director and direct staff are in attendance based on their availability. The members of the governing body attend the Quality Assurance and Performance Improvement meeting if available, however they represent the facility. The Administrator stated all Quality Assurance and Performance Improvement meetings have a sign in sheet and the minutes are what are discussed individually for each issue. The Administrator stated some of the Quality Assurance Performance Improvement issues are ongoing, but the committee reviews everything that is not closed out on a quarterly basis. The Administrator stated the Director of Nursing oversees the Performance Improvement Plans for the Quality Assurance and Performance Improvement meetings.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/4/2025 at 12:27 PM the Director of Nursing stated they oversee the Performance Improvement Plans for the Quality Assurance and Performance Improvement issues. The Director of Nursing stated the meetings are held depending on the progress of the issue. The Director of Nursing stated each issue is addressed in the Quality Assurance meetings by team members, the members determine how long the issue will take to resolve and if another issue of the same kind comes up and they are approaching the finish of a problem, the team then pause the action plan and will revisit the issue. The Director of Nursing stated the Quality Assurance and Performance Improvement meeting for nursing are done separately because they cover a lot of issues with nursing and their next meeting is scheduled for the 1st week of April. The Director of Nursing stated in morning report they discuss issues and Quality Assurance and Performance Improvement plans every Friday. The Director of Nursing stated Quality Assurance and Performance Improvement meetings-consist of the Director of Nursing, nurse managers, nursing supervisors and the Assistant Administrator. The Director of Nursing stated the Administrator is invited to the quarterly meetings, but they are not present for the meetings held on Fridays.</p> <p>10NYCRR 415.27</p>		