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	11/04/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated survey (2621561), the facility failed to ensure that the residents' environment remained as free of accident hazards as possible for one (1) of three (3) residents reviewed for accidents. Specifically, on 09/02/2025 Resident #1 who had a history of being combative with care and required two (2) staff assistance for bed mobility, fell out of bed and sustained a laceration to the left eyebrow when Certified Nurse Aide # 1 turned around to retrieve a mechanical lift pad from the resident's chair. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. Resident #1 had diagnoses including Parkinson's disease (a progressive neuro-degenerative disorder that primarily affects movement), impaired mobility, and falls. The quarterly Minimum Data Set (a resident assessment tool) dated 08/18/2025 documented Resident #1 had severe cognitive impairment, was dependent (helper does all the effort and the resident does none of the effort to complete the activity, or the assistance of two (2) or more helpers is required for the resident to complete the activity) for all activities of daily living, including rolling left and right and transfers. Resident #1 had upper and lower extremity impairments on both sides and no falls or behaviors. During an observation on 10/14/2025 at 2:52 PM, Resident #1 was awake and, in their room, sitting in the Geri-chair with a mechanical lift pad observed in the chair behind the resident. The resident was placed back to bed by Certified Nurse Aide #2 and Certified Nurse Aide #4 via mechanical lift. Resident #1's left side of the bed was against the wall during the resident's transfer. The 09/01/2025 Certified Nurse Aide Kardex documented Resident #1's bed mobility status as dependent on staff to roll left and right.The 09/02/2025 statement written by Certified Nurse Aide #1 documented after they cleaned and dressed the resident, they turned around to pick up the mechanical lift pad and heard the resident hit the floor. The 09/02/2025 Investigative Summary written by Registered Nurse Unit Manager/Supervisor #5 documented that at around 11:30 AM, Registered Nurse Unit Manager/Supervisor #5 was told by Certified Nurse Aide #1 that Resident #1 had fallen and was on the floor. A full body and skin assessment revealed a 2.5-centimeter laceration on the left forehead. A pressure dressing was applied to control minimal bleeding, and the resident's level of consciousness and range of motion remained at baseline. The resident was non-verbal and could not state what happened and was sent to the Emergency Department for a computed tomography scan (an imaging method that uses x-rays) and further evaluation. Certified Nurse Aide #1 stated that after cleaning and dressing the resident, they turned to pick up the mechanical lift pad and heard the resident hit the floor. A reenactment showed that fall precautions were in place: the room was well-lit, the floor was dry and clutter-free, the bed was at the lowest position, and the call bell was within reach while the resident wore non-skid socks. Impaired mobility was identified as a contributing factor. Certified Nurse Aide #1 received a three (3) day suspension (09/16/2025-09/18/2025) as part of corrective action and underwent ongoing in-service re-education on activities of daily living. The facility ruled out abuse, neglect, and mistreatment of the resident. The 09/03/2025 Emergency Department Physician's visit summary documented that Resident #1 did not require hospitalization related to no evidence of traumatic injuries, acute infections, metabolic conditions, or emergencies. They documented the resident can address any urgent needs on an outpatient basis. The discharge plan included continuing prescribed medications/treatment, wound care, and a follow-up with the primary care physician for left eye suture removal in seven (7) days.The 09/03/2025 at 9:19 PM Medical Visit note by Physician #1 documented the resident was sent to the emergency room on [DATE], status post-fall and had a laceration to the left eyebrow. The resident's computed tomography scan was reviewed, and the workup in the hospital was negative; the computed tomography scan had no internal injury or bleeding. The resident's vital signs were stable.During a telephone interview on 10/06/2025 at 8:49 AM, Resident #1's health care proxy stated that the resident cannot move independently and cannot turn over on their own. They stated they were concerned about how the resident fell out of bed when the aide turned away. They stated the resident injured their left eyebrow and was sent to the hospital on [DATE].During a telephone interview on 10/06/2025 at 12:41 PM, Certified Nurse Aide #1 stated that after they finished cleaning the resident following breakfast, they dressed the resident, who was resting in bed against the wall. Certified Nurse Aide #1 stated that the resident was positioned in the bed with their body against the wall, and the bed was in a low position. Certified Nurse Aide #1 stated they turned around to retrieve the resident's mechanical lift pad from their Geri chair to place it under the resident. They stated while they were doing this, they heard