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	11/26/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and interviews conducted during the Abbreviated Surveys (#649784 and #649783), the facility did not ensure that a comprehensive care plan was timely developed to address elopement risk for 1 (Resident #3) of 3 residents reviewed for accidents. Specifically, Resident #3 was assessed as an elopement risk on 09/02/2025 and had a wander guard placed on 09/02/2025 but the elopement care plan was not initiated until 09/04/2025. Review of the Care Plan and the Certified Nurse Aide Assignment/Accountability Record showed that wander guard monitoring instructions were not updated until 09/04/2025.The findings are:The facility policy titled Elopement Prevention and Wandering Behavior Management last reviewed 04/15/2025 documented that if a resident is identified at risk for elopement or unsafe wandering, the registered nurse supervisor must develop or update the elopement prevention care plan, document in the progress notes, ensure the resident is carried on the 24-hour report, and update the Certified Nurse Aide Assignment/Accountability Record (CNAAR) /Nursing Instructions. The policy further stated that the Certified Nurse Aide Assignment/Accountability Record Nursing Instructions must include the body location of the wander guard, notification of the resident's family, and documentation of wander guard placement to ensure Certified Nurse Aide monitoring every shift.Resident #3 was admitted with diagnoses including but not limited to dementia, cerebral infarction and spondylosis of the cervical region.Review of Resident #3's care plan dated 09/02/2025 revealed no documented evidence that a wander guard device was initiated. Nursing progress note dated 09/04/2025 documented a wander guard device was applied to the resident on 09/02/2025.The 09/02/2025 Elopement/Unsafe Wandering Screen documented that Resident #3 wanders, apply a wander guard device, and notify staff of elopement risk/wandering risk.During an interview on 09/04/2025 at 2:14PM, Registered Nurse #2 stated that Certified Nurse Aides are expected to document wander guard checks in a binder at the nurses' station. When the binder was requested, Registered Nurse #2 was unable to provide it, and Registered Nurse #2 stated that staff just know which residents have wander guards.During an interview on 09/05/2025 at 2:52 PM, the Director of Nursing stated that the resident's care plan should have been updated at the time the wander guard was applied, and that it was the nurse completing the assessment or investigation who was responsible for ensuring the care plan was revised to reflect the initiation of the wander guard and the new intervention.During an interview on 09/05/2025 at 4:36 PM, the Director of Nursing stated that they did not know why the registered nurse who completed Resident #3's admission did not initiate the elopement care plan and include the wander guard intervention. The Director of Nursing stated it is the expectation that when a resident is admitted or re-admitted , the admitting nurse develops or revises the care plan to include all interventions and links those interventions to the Certified Nurse Aide Accountability Record so that Certified Nurse Aides are aware of the resident's needs. The Director of Nursing further stated that all registered nurses have been in-serviced and instructed to always implement care plans or revise them to include new interventions. The Director of Nursing confirmed they noticed the Elopement/Wander Guard was missing from Resident #3's care plans and that they initiated the elopement care plan on 09/04/2025 and included the wander guard placement. [10 NYCRR 415.11(c)(1)]

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, record review, and interviews conducted during the Abbreviated Survey (649783), the facility did not ensure that the comprehensive care plan was revised to include measurable interventions to address an identified elopement risk for 1 (Resident #2) of 3 residents reviewed. Specifically, review of the facility's investigation summary dated 03/23/2025 documented that Resident #2 was to be placed on one-to-one supervision at night following an elopement incident. Review of Resident #2's care plan showed that one-to-one supervision intervention was not incorporated into the plan of care. As a result, the resident's comprehensive care plan did not reflect all identified interventions necessary to address their assessed elopement risk. Subsequently on 04/14/2025, Resident #2 eloped again from the facility and was found by local police wandering on a nearby street. The Resident was brought to the emergency room for further evaluation.The findings are:The Facility policy titled Care Plan-Comprehensive revised 06/2025 documented that assessments of residents are ongoing, and care plans are revised as information about the residents' condition change. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes.Resident #2 was admitted with diagnoses including but not limited to adjustment disorder, Dementia with mood disturbance and agitation, and Parkinson's disease.The 01/14/2025 admission Minimum Data Set documented that Resident #2 had severely impaired cognition and exhibited wandering behaviors occurring one to three days during the assessment period. The 03/23/2025 Accident/Incident Report documented that at approximately 5:45 PM, staff discovered Resident #2 was not in their bed. The resident's room was searched, and the resident could not be found. A Code Orange was activated and 911 was called. Police officers responded to the facility to gather information regarding the resident. Shortly thereafter, the facility received a call from the hospital emergency department that Resident #2 had been located and was brought there. Review of the facility's investigation summary dated 03/23/2025 documented that Resident #2 was to be monitored every 30 minutes for three days and placed on one-to-one supervision at night. However, review of the resident's care plan revealed it was not revised to reflect these interventions, and documentation showed the interventions were not implemented, and on 04/14/2025, Resident #2 again eloped from the facility.During an interview on 09/05/2025 at 11:54 AM, Registered Nurse #1 stated that Resident #2's care plan should have been updated to reflect the new interventions indicated after the elopement. Registered Nurse #1 stated that the Care Plans are implemented and revised by the Registered Nurses and that the staff member responsible for the investigation should have updated the care plan to ensure the interventions were reflected.During an interview on 09/05/2025 at 2:52 PM, the Director of Nursing stated that when new care plan interventions are required, the nurse completing an incident/accident report or investigative summary is responsible for revising the care plan to reflect the new interventions. The Director of Nursing further stated that Resident #2's care plan should have been updated to certify and reflect the intervention of one-to-one supervision following the elopement. Registered Nurse #1 explained that revising the care plan to include new interventions is very important because Certified Nurse Aide tasks are generated directly from the care plan, and without revisions, staff would not receive updated directives to implement the required interventions.10 NYCRR 415.11(c)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review and interviews conducted during the Abbreviated Survey (649752), the facility did not ensure that necessary care and services were provided to maintain the resident's highest practicable physical well-being for one (Resident #3) of three residents reviewed for respiratory infections. Specifically, for Resident #3, the facility did not ensure timely medical evaluation and initiation of appropriate treatment after receiving positive laboratory results for Influenza A on 01/31/2025. The Physician was not immediately notified about the test results causing a delay in treatment. The facility treatment plan for the resident was initiated on 02/02/2025. The facility policy titled Influenza Protocol reviewed 04/2025 documented that Influenza antiviral treatment should be administered to residents and healthcare personnel according to current CDC guidelines. Antiviral treatment/prophylaxis should not be delayed while awaiting test results. Resident #3 was admitted with diagnoses including but not limited to malignant neoplasm of cerebellum, diabetes mellitus, multiple sclerosis, and thrombocytopenia.The 02/27/2025 Quarterly Minimum Data Set (an assessment tool) documented that Resident #3 had severely impaired cognition.The laboratory report dated 01/31/2025 documented that Resident #3 had a Respiratory Panel plus COVID test completed on 01/30/2025, with results showing positive for Influenza A. There was no documented evidence that the laboratory results were reviewed or addressed by nursing staff on 01/31/2025 or 02/01/2025. There was also no documentation that the physician was notified. Treatment was not initiated until 02/02/2025, when Tamiflu was prescribed and started.Review of the physician's order documented that Tamiflu 75mg was ordered on 02/02/2025 for resident #3 for positive Influenza A results.During an interview on 09/18/2025 at 12:33 PM, the Medical Director stated they were unable to recall if they were notified of Resident #3's positive results but confirmed that Tamiflu was ordered on 02/02/2025 after they became aware of the Influenza A test results. The Medical Director stated that Tamiflu should be started within 48 hours of a positive result to be most effective and stated that there was a delay in treatment due to a lack of timely communication from nursing staff. The Medical Director also stated that nursing staff could have implemented droplet precautions before the physician was notified and that a physician's order is not required to begin droplet precautions when Influenza is suspected or confirmed.During an interview on 09/18/2025 at 01:27 PM, Registered Nurse Unit Manager #4 stated that the Respiratory Panel plus COVID test was ordered as a precautionary measure during an Influenza outbreak and stated that there was no documentation showing the physician was notified when the positive results were received. Registered Nurse Unit Manager #4 stated that they should have followed up with the physician to obtain timely treatment orders.During an interview on 09/19/2025 at 10:26 AM, the Director of Nursing stated that Tamiflu should be started at the onset of symptoms and no later than 48 hours after a positive Influenza result to ensure effectiveness. The Director of Nursing stated that nursing staff are responsible for promptly notifying the physician of critical results and obtaining treatment orders. The Director of Nursing stated that droplet precautions could have been implemented sooner while awaiting physician notification, and that the delay in starting Tamiflu for Resident #3 represented a delay in treatment and response to the positive Influenza diagnosis.10NYCRR 415.12(a)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, record review, and staff interviews conducted during the Abbreviated Surveys (649784 and 649783), the facility did not ensure that residents at risk for elopement received adequate supervision to prevent accidents for 2 (Resident #1 and #2) of 3 residents reviewed. Specifically, 1) On 1/26/2025, Resident #1 who had documented evidence of elopement attempts and was on one-to-one supervision was left unattended by Patient care Assistant #1 to go on their dinner break. Resident #1 exited the facility without their wheelchair and without detection from staff. The Facility wander guard system did not alarm. Resident #1 was later found at the bus station in front of the building. 2) Resident #2 who had been assessed as an elopement risk exited the facility on 03/23/2025 at 5:48PM without staff detection. Resident #2 was found at a hospital emergency department and returned to the facility with an order for 30minute visual checks for three (3) days and was also placed on a one-to-one supervision at night. On 4/14/2025, at approximately 4:45 AM, a Code Orange was announced for Resident #2. The resident had eloped from the facility and was later located by police walking on a nearby street. Police transported the resident to the emergency room for evaluation. The Facility's wander guard system did not alarm during Resident #1 & #2's exit from the facility. There was no documented evidence that the interventions put in place were implemented.The findings are:The 04/15/2025 policy titled Elopement Prevention/Wandering Behavior Management documented that it is the policy of the facility to utilize all possible measures to maintain the safety and well being of all residents. To have system and tools in place to do all that is reasonable to identify and prevent unsafe wandering and/or elopement and to act quickly and prudently should either occur. The Facility Policy titled One to One Supervision reviewed on 05/2025 documented that staff must maintain visual contact and always be within arm's reach at all times. 1. Resident #1 was admitted with diagnosis including but not limited to anxiety disorder, cerebral infarction, and psychoactive substance-induced psychotic disorder with delusions, and schizoaffective disorder.The 11/05/2024 Annual Minimum Data Set (an assessment tool) documented that Resident #1 had moderately impaired cognition. The 03/17/2024 Physicians Orders documented that Resident #1 had a Wander guard to their left wrist.The 01/26/2025 Investigative Summary documented that on 01/26/2025 at 8:30 PM, Resident #1 was on one-to-one supervision, left unsupervised, was able to breach an exit door and was later found at the bus station in front of the facility.The Elopement Care Plan dated 01/11/2024 documented that Resident #1 was at risk for elopement related to agitation, change of environment, and wandering behavior. Interventions included ensuring that all door alarms are working and may initiate 1:1 as needed.The 12/02/2024 Comprehensive Care Plan Meeting Note documented that Resident #1 will continue one to one supervision due to disruptive behaviors. During an interview on 09/04/22025 at 1:49 PM, Front Desk Personnel #1 stated that their regular work hours are 8:00 AM to 4:00 PM. They explained that they are familiar with residents who wander by referencing the wander guard book kept at the front desk where they are stationed. Front Desk Personnel #1 when asked to provide the wander guard book, they were unable to do so, stating it was in the possession of the Administrator. Front Desk Personnel #1 further stated that the only door equipped to trigger a wander guard alarm is the main entrance door of the facility. During an interview on 09/04/2025 at 11:55 AM, the Director of Nursing stated that Resident #1 activated the fire alarm on the 5th floor. The Director of Nursing stated that when staff responded to the alarm, Resident #1 must have exited the facility through an exit door, but the Director of Nursing was unable to identify which door or exit was used. The Director of Nursing further stated that at the time of the incident, Resident #1 was on a one-to-one supervision, but the assigned Patient Care Assistant #1 was on her break and not with the resident. During an interview on 09/05/2025 at 11:44 AM, Patient Care Assistant #1, stated that they were assigned to provide one to one supervision for Resident #1. They stated that after putting the resident to bed, they informed the nurse to take a break and left the resident unattended to eat dinner. They reported that by the time they sat down to eat at the nurse's station, they heard the door alarm sounding. Patient Care Assistant #1 stated that they went back to the resident's room and Resident #1 was not there. Patient Care Assistant #1 stated that they were aware of the resident's background of wandering and elopement attempts and that Resident #1 was awake when they left the room to go on their dinner break. Patient Care Assistant #1 stated that they were always assigned to Resident #1 for one to one supervision, who often expressed wanting to go home. Patient Care Assistant #1 stated that Residents on one to one supervision are not supposed to be left alone. During an interview on 09/05/2025 at 11:54 AM, Registered Nurse #1 stated that during the

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews conducted during the Abbreviated Survey (649752), the facility did not ensure that infection prevention and control practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for one (Resident #3) of three residents reviewed for respiratory infections. Specifically, on 01/30/2025, Resident #3 had a Respiratory Panel plus COVID test completed, and on 01/31/2025, the results came back positive for Influenza A. The facility did not implement droplet precautions until 02/02/2025. When requested, the facility was unable to provide documented evidence that droplet precautions were initiated after the positive results were obtained on 01/31/2025.The findings are:The facility policy titled Influenza Protocol reviewed 04/2025 documented that droplet precautions should be implemented for residents with suspected or confirmed influenza for 7 days after illness onset.Resident #3 was admitted with diagnoses including but not limited to malignant neoplasm of cerebellum, diabetes mellitus, multiple sclerosis, and thrombocytopenia.The 02/27/2025 Quarterly Minimum Data Set (an assessment tool) documented that Resident #3 had severe impaired cognition.The 01/30/2025 Physicians Orders documented that Resident #3 was to have a Respiratory Panel plus Covid done.The 01/31/2025 laboratory report documented that Resident #3 had a Respiratory Panel plus COVID test completed on 01/30/2025, and the results was positive for Influenza A.During an interview on 09/18/2025 at 12:33 PM, the Medical Director stated that they were unable to recall if they were notified of the Resident #3's positive results because the incident occurred approximately six months prior. The Medical Director reported that, after reviewing text messages and phone call records, there was no evidence of any correspondence from staff regarding Resident #3's Influenza A diagnosis. The Medical Director further stated that they visited Resident #3 on 02/02/2025 after being notified that the resident tested positive for Influenza A, at which time they ordered Tamiflu and initiated contact and droplet precautions. The Medical Director explained that Tamiflu should be started within 48 hours of a positive Influenza A result to be very effective. Nurses are responsible to notify the physician of any abnormal test results. The Medical Director stated that contact and droplet precautions should have been initiated immediately after the positive result was obtained and described this as a delay in treatment and a lack of communication between nursing staff and the physicians. During an interview on 09/18/2025 at 01:27 PM, Registered Nurse Unit Manager #4 stated that a Respiratory Panel plus COVID test was ordered for Resident #3 as a precautionary measure due to an Influenza outbreak at the facility. Registered Nurse Unit Manager #4 stated they did not document in the resident's medical record that a Respiratory Panel plus COVID test was ordered for Resident #3, nor did they document the clinical rationale for ordering the Respiratory Panel plus COVID test They stated that when positive test results are received, the physician must be notified and as a Nurse Manager, they should have followed up with the physician regarding the positive results and obtained a treatment plan to initiate timely. Registered Nurse Unit Manager #4 stated that a physician's order is not required to initiate contact and droplet precautions for positive Influenza result.During an interview on 09/19/2025 at 10:26 AM, the Director of Nursing stated that nursing supervisors are responsible for contacting the physician when there are critical laboratory results. The Director of Nursing stated that positive Influenza results are considered critical because Influenza is highly infectious, and precautionary measures should be initiated immediately, and the physician must be notified immediately. The Director of Nursing stated that if a nurse is unable to reach the primary physician, they should contact another physician for further instructions. The Director of Nursing stated that nursing staff can initiate droplet precautions without a physician's order and that, when a nurse communicates with a physician, the interaction and response must be documented in a nursing progress note. The Director of Nursing stated that when a resident tests positive for Influenza, respiratory precautions should be implemented immediately. The nursing supervisor is responsible for ensuring these protocols are followed. The Director of Nursing stated that this situation represented a delay in treatment and a delay in implementing precautionary measures. The Director of Nursing stated that even if a resident presents with signs and symptoms of a respiratory illness such as sniffling or coughing, staff should wear personal protective equipment as a precautionary measure until test results are obtained.10 NYCRR 415.19