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	04/14/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review and interview the facility failed to ensure each resident who was unable to carry out activities of daily living received the necessary care and services for one (1) of eight (8) residents (Resident #145) reviewed for activities of daily living. Specifically, 1) toileting assistance was not provided every two (2) hours as per comprehensive care plan for Resident #145, who required assistance with toileting. The findings include:The policy and procedure for activities of daily living last reviewed on 5/2025, documented established guidelines for providing comprehensive assistance with Activities of Daily Living to residents. It aims to ensure that each individual's basic needs are met while promoting dignity, independence, and comfort. This policy applies to all caregivers, nurses, and staff involved in the direct care of residents who require assistance with Activities of Daily Living, including but not limited to toileting, mobility and transferring. Supervisors/Managers to oversee the implementation of care plans.1)Resident #145 was admitted to the facility with diagnoses including overactive blader, muscle weakness and localized swelling, mass and lump, unspecified lower limb. The Minimum Data Set (resident assessment) dated 12/27/2024 documented Resident #145 had moderately impaired cognition and was dependent on staff for chair to bed transfer and required substantial assistance with toileting and personal hygiene. The Care Plan for bowel incontinence dated 12/21/2024, documented check resident every two hours and assist with toileting as needed, provide a bedpan or bedside commode.The Care Plan for dependance on staff in meeting activities of daily living needs last reviewed on 12/27/2024, documented Resident #145 required partial to moderate assistance with toilet transfer, toileting and personal hygiene. The Kardex Report dated 4/9/2026, documented toileting, check the resident every two (2) hours and assist with toileting as needed, provide bedpan or bedside commode, and provide peri care after each incontinent episode.During observation and interview on 4/7/2026 at 9:46 A.M., Resident #145 was sitting on the edge of the bed watching a laptop.The resident stated the night shift changed their brief at approximately 6:30 A.M.During observation and interview on 4/07/2026 at 2:48 P.M., Resident #145 stated their brief was wet for approximately two (2) hours and stated they expected that staff would come back and change them. They stated no staff offered toileting assistance since the morning care provided by the night shift. During observation and interview on 4/08/2026 at 11:35 A.M., Resident #145 stated that they were assisted with toileting at approximately 9:00 A.M., and no staff had offered toileting assistance since then.During observation and interview on 4/09/2026 at 11:30 A.M., Resident #145 stated they had been incontinent about hour ago and expected that the staff would come and change them, but no staff had offered toileting assistance.During observation and interview on 4/09/2026 at 1:07 P.M., Resident #145 was in their wheelchair. The resident stated they had been incontinent since approximately 10:30 A.M. and nobody offered them assistance with toileting. During an interview on 4/9/2026 at 1:09 P.M., Certified Nurse Aide #1 stated Resident #145 required two-person assistance for transfers and was toileted in bed due to safety concerns with transfers. Certified Nurse Aide #1 stated toileting should occur every two (2) hours, however, they stated that on 4/7/2026 they did not provide toileting assistance to Resident #145 until approximately 1:00 P.M. due to being busy with documentation at the end of the shift. Certified Nurse Aide #1 stated that on 4/9/2026, the last time Resident #145 was toileted was around (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:00 A.M., during morning care and that no additional toileting checks had been performed as of the time of the interview. During an interview on 4/9/2026 at 2:12 P.M., Licensed Practical Nurse # 2 stated the resident required two-person assistance with transfers and believed the resident should be toileted approximately every two (2) hours. Licensed Practical Nurse #2 was unable to state the frequency of toileting provided. During an interview on 04/10/2026 at 9:40 A.M., the Registered Nurse Supervisor # 3 stated although Resident #145 could be transferred with two-person assistance to the bathroom or commode posed safety and privacy concerns due to the tight space in the bathroom, which requires both doors to remain open during transfers and toileting. Registered Nurse Supervisor #3 stated that the most appropriate and safe intervention for the resident was to provide frequent toileting in bed at a minimum of every two (2) hours. Registered Nurse Supervisor #3 stated they were not aware of how often staff were actually checking or toileting the resident. 10 New York Code Rules Regulations 415.12 (a)(3)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interviews during survey, the facility failed to ensure that the residents' environment remained as free of accident hazards as is possible with the use of assistive device for one (1) (Resident #169) of four (4) residents reviewed for accidents. Specifically, the use of a left-enabler bar (bar attached to the bed designed to facilitate movement, improve safety) was not implemented as per physician order for Resident #169, which resulted in a 04/05/2025 fall from bed when Certified Nurse Aide #8 turned Resident #169 onto their left side during care. Subsequently, Resident #169 was transferred to the hospital and diagnosed with a right intertrochanteric (thigh bone) fracture (broken bone). This resulted in actual harm to Resident #169 that was not Immediately Jeopardy. The findings included: The Assessment for enabler bars dated 01/13/2025 completed by the rehabilitation department documented an enabling device is indicated to promote independence. Left-enabler device recommended. Request made to maintenance to install an enabling device. Nursing notified.Resident #169 had diagnoses including obesity (excessive body fat), paraplegia (inability to voluntarily move legs), and generalized weakness.The Physician Order dated 01/14/2025 documented left-enabler bar for bed mobility to aid in turning and positioning on every shift.The Care Plan for enabler-bar dated 01/14/2025 documented may use enabler bars. There was no documented evidence that goals and interventions were added to the Care Plan to address the use of enabler bars prior to 05/06/2025. The admission Minimum Data Set (a resident assessment tool) dated 01/17/2025 documented Resident #169 was cognitively intact, had functional impairment of one (1) upper extremity (arm) and both lower extremities (legs), was dependent with rolling from their back to side and was not at risk for falls.The Accident and Incident form dated 04/05/2025 at 5:30 AM completed by Registered Nurse #21 documented that Resident #169 slipped off the bed when Certified Nurse Aide #8 was turning the resident. Resident #169 had no visible injury but was holding their head in pain and complaining of pain in their lower extremity. Review of the written statement completed by Certified Nurse Aide #8 dated 04/05/2025 documented that they were giving care to the resident. They turned the resident to the left to clean the resident, and the resident started to shake. The right leg slipped down, and the resident fell out of bed. There was no documented evidence on the 04/05/2025 Accident and Incident form that indicated a left enabler bar was in place. There was no documented evidence on the 04/01/2025 - 04/31/2025 Certified Nurse Aide Follow Up Question Report to address the use of a left enabler bar.The Progress Notes dated 04/05/2025 at 6:12 AM by Registered Nurse Supervisor #21 documented the floor nurse called for assistance. The resident had a fall at 5:30 AM. The resident rolled off the bed during care (as per certified nurse aide). The resident was holding their head in pain, with no change in mental status, and no visible injury was noted. The Medical Doctor was notified and ordered a transfer to the emergency room for an X-ray of the head to rule out a head injury. Emergency Medical Services on its way.The Emergency Department Visit Summary dated 04/05/2025 documented that Resident #169 had a right intertrochanteric fracture.The Progress Note dated 04/11/2025 at 5:17 PM written by Registered Nurse Supervisor #21 documented the resident was readmitted from the hospital at 3:30 PM. The resident was brought in by ambulance and escorted by two (2) staff members. The resident had been treated for a right hip fracture after a fall and had undergone a surgical procedure with right gamma nailing (internal fixation of fracture). The resident was received in stable condition, alert, and oriented times three (3). The resident had a surgical wound on the right hip region. All orders were carried out, the Medical Doctor was notified, and the resident was made comfortable. The resident was to be continually monitored.The Summary of Investigation dated 04/15/2025 documented Resident #169 was on skilled physical and occupational therapy for therapeutic exercises and activities for activities of daily living training secondary to deconditioning. The resident used a left-enabler bar for bed mobility and was dependent on staff in most areas of activities of daily living. Certified Nurse Aide #8 was interviewed and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	recounted that they were providing care to the resident when, upon turning the resident to the left side, the resident started to shake, which led to the resident's right leg slipping off the bed, dragging the resident's whole body down to the floor. The resident was sent to the hospital for evaluation. The resident was care planned for one (1)-assist for bed mobility. There was no documented evidence on the 04/15/2026 Summary of Investigation that indicated a left enabler bar was in place. During an interview on 04/10/2026 at 1:43 PM, Physical Therapist #22 stated Resident #169 required substantial/maximum assistance (required 75 percent assistance; could only do a little for themselves). They stated Resident #169 required one (1) assist for bed mobility.During an interview on 04/14/2026 at 3:12 PM, the Director of Nursing stated Resident #169 had a left-enabler bar since January 2025. They stated they signed off on the accident/incident report completed on 04/05/2025 but were not aware if the left-enabler bar was in the up position. They stated they could not say if the left-enabler bar in the up position would have prevented the fall.During a telephone interview on 04/14/2026 at 3:40 PM, the Medical Director/Primary Physician stated they were familiar with Resident #169's condition and they were notified that Resident #169 had a fall that resulted in a hip fracture. They stated the left-enabler bar would have helped Resident #169, but when the resident slid off the bed, their motion was strong, and the resident kept falling.During an interview on 04/13/2026 at 9:34 AM, Resident #169 stated Certified Nurse Aide #8 turned and pushed them over too far. Resident #169 stated they fell on their right hip. They had surgery and had rods/screws placed in the right hip. They stated now they could help with turning because they have side rails, but before the fall they did not have enablers. Resident #169 stated that their condition caused spasms and prevented movement from their waist down. They stated they did not have spasms when they fell.During a telephone interview on 04/13/2026 at 11:49 AM, Certified Nurse Aide #8 stated they were giving Resident #169 peri care and turned the resident to wipe them. Resident #169's leg started to shake, and the resident slid out of the bed very quickly and fell on their right side on the floor. They stated the resident was on their assignment and this was not the first time they had taken care of the resident. They stated the resident needed one (1) assist for care, turning, and positioning.During an interview on 04/13/2026 at 1:20 PM, Registered Nurse #9 stated they were called to Resident #169's room by Certified Nurse Aide #8. They stated Resident #169 was on the floor complaining of a little back pain; no injury was observed, no bleeding, no mental status changes. They stated they called the nursing supervisor. They stated they took the resident's vital signs. They stated they could not recall Resident #169 having bed enablers. They stated the resident fell on the left side of the bed.During an interview on 04/14/2026 at 5:02 PM, the Administrator stated that the enablers on the second-floor beds could not be lowered/raised. They stated that all beds on the second floor were new in April 2025, and those are the same beds currently on the second floor. All enablers that were in place were fixed and could not be moved without tools. They stated that former Registered Nurse Supervisor #21, who completed the Accident/Incident report form, may not have seen the enabler at the time of the resident's fall, and that it may have been obscured by the mattress. The Administrator stated they reviewed the Accident/Incident Report and signed off on it but did not notice the discrepancy in the documentation regarding the enabler bar.10 NY CRR 415.12 (h)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews during recertification survey and abbreviated survey (# 649776), the facility failed to ensure that food was stored and prepared in accordance with professional standards for food service safety. Specifically, 1) Resident #153 had complaint of expired milk in July 2025 2) the kitchen refrigerator/freezer and unit 4/unit 5 pantries contained unlabeled and undated food, 3) the unit 4 pantry and the kitchen contained expired foods and 4) milk was not maintained at the proper temperature. The findings include: The policy and procedure titled Storage of Perishable Goods reviewed 05/2025 documented, prepared foods are covered before storage and container must be labeled indicating content and date stored.The policy and procedure titled Dietary /Food Handling reviewed 06/2025 documented, guidelines for the safe preparation, handling and storage of perishable food: all potentially hazardous food must be maintained at 40 degrees Fahrenheit or less.The policy and procedure titled Staff Pantry Refrigerator Use reviewed 09/2025 dated 2025 documented, the facility provides the bottom drawer of the unit pantry refrigerator for staff use. All food items must be labeled with staff name and date, food must be in sealed containers, items unlabeled, and expired or older than 72 hours will be discarded.The policy and procedure titled Food Brought from the Outside reviewed 09/2025 documented, Food or beverage brought in from the outside will be labeled with the resident's name, room number and dated by nursing with the current date the item that was brought to the facility.1) Resident #153 reported that on 07/05/2025, they were provided milk for their cereal. The milk was added to the cereal and tasted off, as they drank the milk it was curdled and they noticed the date on the carton of milk was 07/03/2025.2) During the initial tour of the kitchen on 04/07/2026 at 9:44 AM the following was observed: a pan of cooked vegan chicken cutlets and veggie burgers unlabeled and undated, an opened brick of [NAME] cheese undated, two (2) open packages of shredded mozzarella cheese undated, pan of frozen peppers thawing in the refrigerator unlabeled and undated, pan of frozen waffles and muffins in freezer unlabeled and undated, and a pan of frozen chicken necks undated. During an observation of the unit 4 pantry on 04/07/2026 at 1:11 PM the refrigerator contained three (3) bags of undated and unlabeled food, unwrapped brick of cheese unlabeled and undated, a stick of butter in a plastic bag unlabeled and undated, and what appeared to be pickle slices in a specimen cup, unlabeled and undated.During an observation of the Unit 5 pantry on 04/14/2026 at 9:41 AM the refrigerator door contained a cut lemon in a plastic cup uncovered, undated and unlabeled, and the freezer contained two (2) fast food drinks with uncovered straws, one (1) undated and one (1) unlabeled.3) During the initial tour of the kitchen on 04/07/2026 at 9:44 AM the refrigerator contained eight (8) cartons of 8-ounce fat free milk with a 03/04/2026 expiration date, and a pan of cooked turkey breasts that expired 03/28/2026.During the observation of the Unit 4 pantry on 04/06/2026 at 1:11 PM the refrigerator contained a container of expired food dated 02/14/2026 and a bag of expired food dated 03/06/2026.4) During the initial tour of the kitchen on 04/07/2026 at 9:44 AM a diet aide assembled a rack of individual juice cups and some individual four (4) ounce portions of milk. The Food Service Director stated the racks were being prepared for the lunch tray line. The milk cups did not feel cold/cool to touch. The Food Service Director obtained a temperature of the milk at 69 degrees Fahrenheit.During an observation and interview on 04/07/2026 at 1:48 PM three (3) residents (Resident #98, #109, and #229) were heard stating the milk tasted sour. All milk cartons were checked for date and were dated 04/09/2026. Temperature of the milk was obtained at 58 degrees Fahrenheit. Registered Nurse Unit Manager #20 stated maybe the milk was warm because the lunch trays were delivered to the unit 30 minutes late. During an observation of the lunch tray assembly in the kitchen on 04/14/2026 at 11:42 AM temperatures were taken by the Food Service Director. The temperature of the milk was 47 degrees Fahrenheit. They stated the milk had not been delivered that long ago and possibly had not been in the refrigerator long enough before tray (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	line started.During an interview on 04/07/2026 at 9:44 AM the Food Service Director stated staff had been educated on labeling and dating items that have been opened, and anyone can discard expired foods. They stated they were not sure why the eight (8) cartons of milk were expired when they had just received a delivery. They stated stock was rotated by the stocking staff person, and everything was dated when it was delivered. The Food Service Director stated they were not aware the diet aide was leaving the rack of juice and milk out of the refrigerator while preparing the rack for the tray line. During an interview on 04/07/2026 at 1:11 PM Registered Nurse Unit Manager #20 stated nursing staff was allowed to put their personal food and drinks in the unit pantry refrigerator, but they must be labeled and dated. They stated nursing staff was responsible for logging the refrigerator temperatures, and disposal of expired, unlabeled, and undated food. They stated they were not sure why there were items in the refrigerator that were expired, unlabeled and undated.10 New York Code Rules Regulations 415.14(h)