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	06/29/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that the resident, resident representative, were informed in writing and in a language and manner they understood for one of eight (Resident #1) residents reviewed for discharge. Specifically, there was no documented evidence in the medical record to indicate the facility had ongoing communication and follow up to address the 05/22/2026 Resident Representative's inquiry regarding Resident #1 being transferred to a skilled nursing facility closer to their home in [NAME] New York. Resident #1 eloped and was subsequently discharged unplanned from the facility on 06/19/2026, and there was no documented evidence that a Notice of Discharge was provided as soon as possible to Resident #1, their Resident Representative and the Ombudsman and there was no documented evidence that the facility offered assistance with post discharge care. The findings include:The Policy for transfer and discharge reviewed 12/2025 documented resident-initiated transfer means the resident or representative has provided verbal or written notice of intent to leave the facility. The medical record must contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility. A resident's expression of a general desire or goal to return home or to the community or elopement of a resident who is cognitively impaired should not be taken as notice of intent to leave the facility.Resident #1 had diagnoses including unspecified dementia, aphasia and depression. The comprehensive Care Plan for Discharge initiated on 08/31/2023 and last revised on 08/31/2023 documented Resident # 1 will remain in long term placement. Include Involve family/responsible parties in discharge planning and provide emotional support as needed.The 05/22/2026 Social Worker Note written by Social Worker # 1 documented resident care plan meeting. Resident #1 could not participate due to impaired cognition. Resident's Representative was able to participate via teleconference. All questions answered, no concerns at this time. Resident's Representative inquired about Skilled Nursing Facility transfer closer to their home in [NAME] New York. Social Worker educated the Resident Representative on Skilled Nursing Facility transfer process and details. Social Worker will request Patient Review Instrument and Screen from the Director of Nursing/Director of Social Work and refer to Skilled Nursing Facility closer to the Resident Representative. Will continue to monitor.The quarterly Minimum Data set (assessment tool) dated 05/23/2026 documented Resident #1 had severe cognitive impairment, and no wandering behavior.The 06/02/2026 at 1:24 PM Social Service Note Resident # 1 remains long term. Will continue to monitor for any changes. Continue with Plan of Care.Resident #1 eloped from the facility unsupervised on 06/19/2026.The discharge Minimum Data set (assessment tool) dated 06/19/2026 documented discharge assessment return not anticipated. unplanned discharge. Discharge status to home/community.06/20/2026 at 06:41 AM Nurse Progress Note Documented Resident #1 remains out of the building.The 06/20/2026 at 02:51 PM Nurse Progress Note documented received a call from the [NAME] Detective who reported that they successfully spoke to Resident #1's Representative and confirmed that Resident #1 had gone to the Resident Representatives house and stayed there overnight. The Detective stated that the Resident Representative had been instructed to notify the facility if Resident #1 intends to (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	return, so that appropriate follow up and the proper discharge process can be conducted. This information has been documented for continuity of care and coordination with all parties involved.During a phone interview on 06/23/2026 at 04:57 PM, the Resident Representative stated Resident #1 was with them at home, and that the resident told them they did not want to be in the nursing home. The Resident Representative stated they spoke to the facility Social Worker yesterday to report that Resident #1 was at their house, and they would be going to the facility to pick up Resident #1's belongings. During a subsequent phone interview on 06/25/2026 at 09:35AM, the Resident Representative stated the Social Worker informed them that Resident #1 was not allowed back because of the way Resident #1 left.During an interview on 06/25/2026 at 11:16 AM Social Worker #1 stated six out of 10 conversations with the resident, the resident would verbalize they wanted to leave the facility, to go home. Social Worker #1 reviewed their Care Plan Note dated 05/22/2026 and stated they were in the process of trying to find placement for the Resident. They stated they attempted to have the resident placed in a local assisted living facility, but the resident did not meet the criteria to be placed. Social Worker #1 stated they were aware that the Resident Representative wanted Resident #1 transferred to another facility. Social Worker # 1 stated they could not proceed forward with the discharge because the Resident Representative never provided them with a list of Skilled Nursing Facilities in their areaDuring a telephone interview on 6/29/2026 at 2:23 PM the Medical Director stated they were aware of the incident on 06/19/2026 when Resident # 1 left the facility. The Medical Director stated Resident # 1 had dementia. The Medical Director stated when a resident was to be discharged , they assisted with discharge plans by sending medication requests to the pharmacy, writing discharge summaries, and assessing residents to ensure they were medically stable. They stated they were not aware that Resident # 1 was discharged from the facility. The Medical Director stated their notes are clinical notes therefore; they did not write a note for the elopement incident or discharged uring an interview on 06/29/2026 at 02:55 PM, the Director of Social Work stated Resident #1 was discharged from the facility as an unplanned discharge. They stated they did not send a discharge notification to the ombudsman. They stated for any unplanned discharge, there should be a signed form that education was provided, and that residents were notified about the risk. They stated there should be documentation in the progress note. They stated they were not sure if the process for unplanned discharge was followed for Resident #1. They stated they did not talk to Social Worker #1 about the discharge of Resident #1. They further stated it was never brought to their attention that Resident #1 wanted to leave the facility.During an interview on 06/29/2026 at 04:21 PM the Administrator stated Resident #1 eloped, and their Representative had no intention of bringing them back. They stated the Resident Representative came in on Friday to pick up the resident's belongings. They stated the elopement itself was a discharge. They stated they would double check if there was a discharge note.10 New York Code Rules and Regulations 415.3

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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 observation, interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and/or revised for two of 36 residents (Resident #1, Resident #2) reviewed for care plan. Specifically, 1. for Resident #1 who was assessed on 05/20/2026 to be at risk for elopement and refused to wear a wander guard the comprehensive Care Plan was not reviewed and/or revised to address every one hour head count/visual checks and 2. for Resident #2 there was no documented evidence that the comprehensive Care Plan was reviewed and/or revised to address certified nurse aide reports that Resident #2 did not always wear a wander guard and a 06/23/2026 at 2:14 PM observation of Resident #2 without a wander guard. Additionally, the Care Plan was not updated to reflect the change to the wander guard serial # 8CC1CA after a new wander guard was provided on 06/23/2026. The findings include: The policy for comprehensive Care Plan reviewed 09/20/2025 documented an individualized comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Care Plans are revised as changes in the residents' condition dictate. 1.Resident #1 had diagnoses including unspecified dementia, aphasia and depression. The 05/20/2026 Elopement Assessment indicated Resident #1 had a score of 1.0 (at risk). The comprehensive Care Plan dated 05/20/2026 documented Resident #1 was at risk for elopement and refused the wander guard. Encourage the resident to attend facility sponsored activities, ensure all door alarms are working, ensure Interdisciplinary Team is aware of the wandering and elopement risks, involve family in the plan of care, and a picture of the resident was to be given to the front desk for an additional layer of monitoring. There was no documented evidence in the comprehensive Care Plan to address every one-hour head count/visual checks. The quarterly Minimum Data set (assessment tool) dated 05/23/2626 documented Resident #1 had severe cognitive impairment, no wandering behaviors, no impairment in upper and lower extremities, and ambulated with supervision or touching assistance. 2. Resident #2 was admitted with diagnosis including dementia, bipolar, psychosis, and anxiety. The 02/27/2026 comprehensive Care Plan for risk for elopement related to confusion and memory lapse documented wander guard to the right wrist serial # 8CC1CA, distract resident with another activity when risk is more prevalent, encourage resident to attend facility sponsored activities, ensure all door alarms are working, ensure Interdisciplinary Team is aware of the wandering and elopement risk. The 03/01/2026 comprehensive Care Plan documented poor safety awareness due to attempt to leave the facility, dementia; Wanders with no rational purpose. Approach calmly when redirecting resident, family to inform staff when ending visit, initiate code orange if an elopement occurs, invite and encourage participation in activities program, and place name band. The 05/29/2026 quarterly Minimum Data Sat documented severe cognitive impairment, and no wandering behavior. During observation and interview on 06/23/2026 at 2:14 PM, Resident #2 was observed sitting in the day room, without the wander guard. Certified Nurse Aide #2 stated that Resident #2 had no wander guard on. Certified Nurse Aide #2 stated Resident #2 must have removed the wander guard and stated the wander guard must be in Resident #2's room. Certified Nurse Aide #2 left the day room and upon return stated they found the wander guard in the resident room. During an interview on 06/23/2026 at 2:19 PM, Certified Nurse Aide # 8 stated Resident #2 had their wander guard on that morning. Certified Nurse Aide #8 stated that Resident #2 sometimes removed their wander guard. During an observation on 06/23/2026 at 2:30 PM, Resident's # 2's wander guard was carried over to the elevator, after the elevator door closed surveyors were able to reach the basement with the wander guard in hand. The elevator alarm did not activate.During an interview on 6/24/26 at 4:12 PM Certified Nurse Aide # 6 stated that they are able to monitor the residents on the unit because the door is closed and when someone comes on the unit or leaves the bell will ring. They stated the bell is an alert for them to watch the door to see who is entering the unit and who is leaving the unit. They stated Resident # 2 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed their wander guard at times. They stated if the wander guard was not in place, then they searched the room. They stated Resident # 2 placed the wander guard in their drawer. Certified Nurse Aide # 6 stated if the wander guard was not in place on Resident # 2's they would report it to the nurse. They stated Resident # 2 had the wander guard in place when they arrived on shift today and that they were never told that Resident # 2 removed their wander guard yesterday. There was no documented evidence that the comprehensive Care Plan was updated with measurable goals and interventions to address certified nurse aide reports that Resident #2 did not always have a wander guard on and observation of Resident #2 without the wander guard on 06/23/2026. During an interview on 06/24/226 at 4:18 PM Registered Nurse Supervisor # 1, stated that on 06/23/2026 the Assistant Administrator informed them that Resident # 2 did not have a wander guard. Supervisor # 1 stated the Assistant Administrator gave them a new wander guard for Resident #2. Supervisor #1 stated the care plan was supposed to be updated but it was not. Supervisor #1 stated they were responsible for documentation but stated that they missed it. 10 New York Code Rules Regulations 415.11(c)(2)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure each resident received adequate supervision and/or assistive devices to prevent elopement for two of six residents (Resident #1, Resident # 2) reviewed for elopement. Specifically, 1) Resident #1 was assessed as an elopement risk on 05/20/2026, refused a wander guard and was placed on hourly head counts. On 06/19/2026, Resident # 1 eloped from the facility with the last hourly head count for Resident #1 documented at 10:00 AM. Subsequently, the Nurse Progress Note dated 06/20/2026 at 01:00 PM documented the facility received a phone call from a detective at the [NAME] Police Department, who confirmed that Resident # 1 had gone to Resident # 1's Representative's residence (Manhattan) and stayed there overnight; and 2) Resident #2's medical record revealed that the resident had a physician order for a right wrist wander guard and was assessed on 05/26/2026 as an elopement risk. On 06/23/2026 at 02:14 PM, Resident # 2 was observed sitting in the dayroom with no wander guard in place. The facility's failure to conduct an hourly head count to monitor Resident #1 who was an elopement risk resulted in Resident #1 eloping from the facility which posed a likelihood for serious injury, serious harm, serious impairment, or death that was Immediate Jeopardy and Substandard Quality of Care. The findings include:The facility's policy titled Elopement Prevention/Wandering Behavior Management last reviewed on 09/05/2025 documented utilize all possible measures to maintain the safety and well-being of all residents. Have system and tools in place that are reasonable to identify and prevent unsafe wandering and/or elopement and act quickly and prudently should either occur.1) Resident # 1 had diagnoses that included but were not limited to dementia (loss of thinking, remembering and reasoning skills), aphasia (communication disorder affecting speech and understanding), and depression (mood disorder that causes persistent sadness and loss of interest).The Elopement assessment dated [DATE] documented that Resident # 1 had a score of 0, (not an elopement risk).The Nursing Progress Note dated 05/20/2026 at 04:55 PM documented staff reported that the resident was observed unescorted and smoking in the patio area. Resident # 1 stated, I like to smoke sometimes, not every day. Resident # 1 was educated regarding the facility's smoking policy and informed them that a smoking contract will be required. Resident # 1 verbalized understanding. Resident # 1 was also reminded that they were not permitted on the patio without staff supervision. When asked if they had a lighter or extra cigarettes, Resident #1 refused and refused to consent to a room search. Resident # 1 also refused to have a wander guard. Resident # 1's picture was given to the front desk. Social Worker #1 was notified. The Medical Director was notified. Review of Elopement assessment on 05/20/2026 indicated that Resident # 1 had a score of 1; indicating the resident was an elopement risk.The Comprehensive Care Plan for elopement dated 05/20/2026 documented Resident# 1 was at risk for elopement and Resident #1 refused the wander guard. Encourage facility sponsored activities. Ensure all door alarms are working. Ensure Interdisciplinary team is aware of the wandering and elopement risks. Involve the family in the plan of care. Picture of the resident to be given to the front desk for additional layer of monitoring. Wandering and elopement risk assessment must be initiated upon admission and as needed.The quarterly Minimum Data Set (a resident assessment tool) dated 05/23/2026 documented Resident #1 had severe cognitive impairment, did not document that resident had wandering or exit seeking behaviors. Instead, it documented that there were no behaviors, no impairment to the upper and lower extremities, and there was no wander alarm in place.Review of the 5th floor headcount/visuals checks for 07:00 AM- 03:00 PM shift for 06/19/2026 documented that Resident #1 was last seen in the facility at 10:00 AM, by using a code 4 which indicated Resident #1 was in the dayroom. There was no documented headcount/visual check for Resident #1 after 10:00 AM on 06/19/2026. The nursing progress note dated 06/20/2026 documented on 06/19/2026 while the writer was in the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dining room during dinner, Certified Nurse Aide # 1 reported that Resident # 1 was not in their room (dinner arrived on the unit late, approximately 06:20 PM). Facility elopement protocol was followed. Front desk announced Code Orange (staff alert). Room search was done. The nursing supervisor (Nursing Supervisor # 1) was notified.The Nursing Progress Note dated 06/20/2026 at 09:21 AM written by Registered Nursing Supervisor # 1 Late Entry for 06/19/2026 at 07:00 PM, documented Resident # 1 was observed not in their bed, Code Orange initiated, and a comprehensive facility search was conducted; 911 was contacted. Resident #1's Representative was notified and reported that Resident #1 had called them stating they were outside the facility. Law enforcement remains actively engaged in the search, and the facility will continue to follow up for updates.The Nursing Progress Note dated 06/20/2026 at 1:00 PM, documented the facility received a phone call from a detective at the [NAME] Police Department, who reported that they successfully spoke with Resident #1's Representative. The detective confirmed that Resident #1 had gone to Resident #1's Representative's residence and stayed there overnight. During a telephone interview on 06/23/2026 at 04:57 PM, Resident #1's Representative confirmed that Resident #1 was at home with them, and that Resident #1 took three buses to get to Manhattan where they are located. They stated when Resident #1 arrived, they were dressed appropriately. Resident #1's Representative stated the facility informed them that the resident left the facility. Resident # 1 stated to them that they did not want to be in the nursing home, and they were uncomfortable, and wanted to go back to the hospital as opposed to the nursing home. Resident #1's Representative stated that every second or third conversation with the resident, the resident verbalized to go home. A police officer did a wellness check and confirmed that Resident #1 was there. Resident #1 answered the door when the police knocked. Resident #1's Representative stated they spoke to Social Worker # 1 yesterday to report that Resident #1 was at their house, and they would come to the facility to pick up their belongings. Resident #1's Representative stated when Resident # 1 arrived, they had no bruises and no evidence of altercation. During an interview on 06/24/2026 at 10:12 AM, the Director of Nursing stated they suspended staff involved who were working on the day of 06/19/2026. They stated Resident #1 looked like a visitor, and for over a year Resident #1 did not attempt to leave. The Director of Nursing stated on the date of the incident, 06/19/2026, Resident #1 was able to walk out of the building without staff noticing. They stated when staff passed the dinner tray at approximately 06:00 PM - 06:30 PM, staff did not see Resident # 1 and reported to the supervisor. Code Orange was initiated, and police were notified.During an interview on 06/25/2026 at 11:19 AM, Social Worker #1 stated they were aware that Resident #1's Representative wanted the resident to transfer to another facility. Social Worker #1 stated Resident #1 had a speech impairment and had mentioned to them during six out of 10 conversations that they wanted to leave the facility. Social Worker #1 stated Resident #1 was ambulatory, frequently went to the basement to get money, and would go to the vending machine in the basement independently. Social Worker #1 stated Resident # 1 was never at risk for elopement. Social Worker #1 stated Resident # 1 had a daily routine which included sitting on a chair by their room, going to the basement and business office, or going to the vending machine for snacks.During a telephone interview on 06/25/26 at 12:10 PM, Registered Nurse #1 stated Resident #1 never verbalized to them that they wanted to leave the facility. Resident #1 was an elopement risk and was supposed to have a wander guard but refused it. They stated if residents were an elopement risk, other interventions were put in place such as head count every hour to check the resident. They stated that 06/10/2026, they arrived at work for the 3:00 PM-11:00 PM shift, did rounds and did not see Resident #1 on initial rounds. They stated they assumed that Resident #1 was off the unit because that was their normal routine. They stated the certified nurse aide assigned to the resident never reported to them that Resident #1 was not accounted for in the head count. They stated they were not made aware that Resident #1 was missing until the dinner tray was passed by Certified Nurse Aide #1. They stated Resident #1's routine was to go throughout the building unsupervised, and they were not concerned about supervision because Resident #1 would return to the unit. They stated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the hourly head count was the prevention of elopementDuring a telephone interview on 06/29/2026 at 02:23 PM, the Medical Director stated they were aware of the incident on 06/19/2026 concerning Resident #1's elopement. They stated Registered Nursing Supervisor #1 called them to report Resident #1 was missing from the facility. The Medical Director stated they did not write a note on the elopement for Resident # 1. They stated the facility notified them that the police were called, and they did not know exactly what happened. The Medical Director stated they did not remember if anyone reported to them that the resident was found. The Medical Director stated they were responsible for resident care and addressing clinical needs.2. Resident # 2 had diagnosis that included but were not limited to unspecified dementia, (loss of thinking, remembering and reasoning skills), psychotic disturbance, mood disturbance (loss of contact with reality, disorganized thinking), anxiety (feeling of worry and unease), and bipolar disorder (significant mood swings)The quarterly Minimum Data Set, dated [DATE] documented Resident#2 had severe cognitive impairment with no behaviors. Resident 2 had no impairments to the upper and lower extremities and had a wander/elopement alarm.The Comprehensive Care Plan for Elopement, last revised 02/27/2026, documented Resident #2 was at risk for elopement related to confusion and memory lapses. Wander guard to the right wrist, serial # 8CC1CA expiration date 2/20/2026. Distract resident with another activity when risk is more prevalent. Encourage facility sponsored activities. Ensure all door alarms are working. Ensure interdisciplinary teams are aware of the wandering and elopement risk. Notify provider of resident risks for wandering and elopement. Psychiatric consult as needed. Wandering and elopement risk assessment must be initiated on admission and as needed.The Physician Orders dated 02/20/2026 documented Wander Guard to the right wrist- Check placement every shift and monitor for safety.The Elopement assessment dated [DATE] documented that Resident # 2 had a score of 1, (an elopement risk).During an observation on 06/23/2026 at 02:14 PM, Resident # 2 was in the dayroom on the Behavior Monitoring Unit with no wander guard in place.During an interview on 06/23/2026 at 02:19 PM, Certified Nurse Aide # 8 stated Resident # 2 was on their assignment. They stated five residents on their assignment had wander guards in place. Certified Nurse Aide # 8 stated Resident #2 had a wander guard in place this morning on their left ankle when they assisted Resident #2 with putting on their socks. Certified Nurse Aide #8 stated Resident #2 sometimes takes off the wander guard. Certified Nurse Aide #1 stated the purpose of wander guard, was to sound an alarm if the resident attempted to get on the elevator. They stated this would prevent them from leaving the unit.During an observation on 06/23/2026 at 2:30 PM, Resident's # 2's wander guard was carried over to the elevator, after the elevator door closed surveyors were able to reach the basement with the wander guard in hand. The elevator alarm did not activate.During an interview on 6/23/2026 at 02:40 PM, the Administrator was informed that Resident #2 did not have their wander guard in place and that Resident #2's wander guard was checked for functioning and did not activate the elevator alarm. The Administrator stated that the system was checked and functioning properly. Administrator stated the facility also conducts hourly head counts, and there is binder at the front desk that identified all residents that are an elopement risk.During an interview on 06/23/2026 at 02:40 PM, the Director of Nursing stated when a resident refused to wear a wander guard, the facility conducted hourly monitoring and documented the monitoring on paper. 10 New York Code Rules Regulations 415.12(h)(2)The survey team identified Immediate Jeopardy, and the facility Administrator was notified on 06/25/2026 at 04:15 PM.On 06/26/2026 at 08:43 PM, the survey team determined the Immediate Jeopardy was removed based on the following corrective actions taken by the facility:a. Termination of employees that did not follow the facility's protocol for elopement.b. Elopement Assessments for all ambulating residents reviewed on 06/20/2026 and updated if necessary.c. Nursing department continued to conduct hourly headcount/visual checks for all residentsd. The functionality check audit for the wander guard was updated on 06/23/2026 to be individualized for each resident with a wander guard and will continue to be completed nightly.e. Certified Nurse Aides checked placement of the wander guards every shift.f. Elopement policy was reviewed and revised to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	include headcount and visual checks. A designated binder will be kept at the security desk for a list of residents at risk for elopement along with their pictures and identifying information regarding each resident.g. Elopement education and lesson plan in-services were conducted. Employee roster received with education sign off sheets. As of 06/26/2026 according to provided roster and education sign off sheets, of employees have been educated as follows: Nursing 174/183=95%, Rehabilitation 31/33=94%, Dietary 29/30= 97%, Maintenance 4/4=100%, Administration 17/22=77%, Social Work-4/4=100%, Recreation 10/10=100%, Housekeeping 26/26=100%. Total number of staff educated 297/314= 94.6%.