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	12/18/2024

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39308 Based on record review and interview conducted during the recertification survey from 12/11/24 to 12/18/24, the facility did not ensure the resident's right to manage their financial affairs and a resident provided written authorization prior to depositing the resident's funds with the facility 1 (Resident #162) of 2 residents reviewed for personal funds. Specifically, the facility did not inform Resident #162 upon receipt of the resident's tax refund checks in the mail and did not obtain written authorization from Resident #162 prior to depositing the tax refund checks in a facility's operating account. The findings are: The facility policy titled Privacy and Confidentiality dated 5/2024 documented personal privacy and confidentiality of each resident is maintained. The facility policy titled Personal Needs Accounts/Resident Fund Account dated 5/2024 documented all residents were offered a personal needs account, and monies deposited to a personal needs account would be held in an interest-bearing account separate from the facility's operating accounts. The facility policy titled Resident Rights dated 6/2024 documented residents had the right to manage their own financial affairs. Resident #162 was admitted with diagnoses including right leg above the knee amputation, depression, and post-traumatic stress disorder. The Annual Minimum Data Set 3.0 assessment dated [DATE] documented Resident #162 was cognitively intact. During the Resident Council Meeting held on 12/11/2024 at 2:00 pm, Resident #162 reported the facility did not inform the resident income tax return checks mailed to Resident #162 at the facility were received, opened, and deposited in a facility account. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview was conducted on 12/13/2024 at 11:01 AM, and Resident #162 stated the Internal Revenue Service mailed two separate tax refund checks to the facility. Resident #162 inquired with the Internal Revenue Service about the status of their tax refund checks when they did not receive the checks in the mail as expected and was informed the checks had been deposited into a facility-owned bank account. Resident #162 stated they have lived at the facility for approximately 4 years, has never consented to the facility opening their mail or managing their finances, and received no information or communication from the facility regarding who was responsible for opening the resident's mail and where their tax refund monies were currently located. Resident #162 filed a claim with the Internal Revenue Service that Resident #162 did not receive nor cash 2 income tax refund checks and requested the checks be reissued. The first check in the amount of $1,825.02 was dated 7/28/2023 and the second check in the amount of$1,957.42 was dated 6/24/2024. The facility Resident Funds Ledger documented Resident #162 received an Allowance credit to their Funds account on 8/31/2023 for $1825.02 and on 7/31/2024 for $1,957.42. On 11/30/2024, the Resident Funds Ledger documented $1825.02 had been subtracted from Resident #162's and the current balance was $1, 957.42. There was no documented evidence Resident #162 received and was informed of the facility's Admission Agreement, including the facility's practices and responsibilities regarding resident finance management and the resident's right to manage their own finances. There was no documented evidence Resident #162 consented to having their mail opened by the facility Business Office, a personal needs account being established by the facility, the facility financially managing their income and assets, and depositing 2 tax refund checks into the facility's account. During an interview on 12/16/2024 at 1:25 PM and 12/18/2024 at 11:00 AM, the Business Office Manager stated a Internal Revenue Service tax refund check for $1825.02 was deposited into Resident #162's account in 8/2023. Another tax refund check issued in 7/2024 for $1957.42 was also deposited into Resident #162's account. The Business Office Manager stated that, on 11/30/2024, the Internal Revenue Service accessed Resident #162's account and withdrew $1825.02. The Business Office Manager stated the Business Office did not inform Resident #162 that the Business Office opened their mail and deposited checks made out to the resident. A quarterly personal needs account statement was provided to Resident #162 in 7/2024. The Business Office planned to provide Resident #162 with an updated quarterly statement within the next week reflecting changes to the account and the current balance. The Business Office Manager stated Resident #162 did not express any concerns related to their mail or funds to the Business Office. Documented evidence of Resident #162's written authorization allowing the facility to manage their finances and records of all transactions related to Resident #162's tax refund checks were requested. The Business Office Manager stated they were unable to provide any documented evidence the facility obtained consent to manage Resident #162's finances and detailed accounting and/or transaction history once the Business Office received and took possession of Resident #162's tax refund checks. The Business Office also The Business Office Manager was unable to explain how or provide documented evidence the Internal Revenue Service accessed an account managed by the facility and withdrew $1825.02. On 12/16/2024 at 1:30 PM, the Long-Term Care and Business Office Coordinator was interviewed and stated the Business Office received all mail addressed to residents before the mail is delivered to the residents. The Business Office sorted through and opened all resident financial correspondence, including checks ordered to be paid to the resident, and deposited any funds into the resident accounts. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/2024 at 4:57 PM, the Administrator was interviewed and stated they were hired by the facility in 5/2024 and was not involved in the operations of the Business Office. The Administrator stated residents had the right to privacy and confidentiality and mail was delivered to the residents unopened. The Administrator stated they were unaware the Business Office opened resident mail and did not know the Business Office practice and accounting principles related to management of resident personal needs accounts and which banking institutions the facility used to safeguard and hold resident personal funds. The Administrator stated they were unaware Resident #162 had concerns related to unauthorized deposits of their tax refund checks by the Business Office after mail addressed to Resident #162 was opened without their knowledge or consent. The Administrator stated the facility would have to investigate the matter. 10 NYCRR 415.26(h)(5) 48850 Based on record review and interview conducted during the recertification survey from 12/11/24 to 12/18/24, the facility did not ensure a system that assures a full and complete accounting of each resident's personal funds. This was evident for 1 (Resident #162) of 2 residents reviewed for personal funds. Specifically, the facility was unable to provide a clear and detailed accounting of Resident #162's personal funds including a copy of all account transaction history and was unable to provide documented evidence that financial records were available to the resident through quarterly statements and upon request. The findings are: Resident #162 was admitted with diagnoses including right leg above the knee amputation, depression, and post-traumatic stress disorder. The Annual Minimum Data Set (Resident Assessment) dated 09/02/2024 documented Resident #162 had intact cognition. During a resident council meeting on 12/11/2024 at 2:00 pm, Resident #162 stated the facility opened their 2 checks from Internal Revenue Service and deposited them in the facility account without informing Resident # 162 about the checks. During a follow-up interview with Resident #162 on 12/13/2024 at 11:01 AM, Resident #162 stated they contacted and were informed by the Internal Revenue Service that two refund checks had been mailed to the facility address and both checks were deposited into the facility's account. Resident #162 stated the first check, dated July 28, 2023, was for $1,825.02, and the second check, dated June 24, 2024, was for $1,957. 42. Resident #162 stated they had not been informed and did not receive any statements of a personal funds account. There was no documented evidence the facility provided Resident #162 with detailed transaction history, specific account information, or quarterly statements with interest accrued and other accounting details of the resident's personal funds since their tax return check was first deposited in 8/2023. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/24 at 1:25 PM the Business Office Manager stated Resident #162 was not informed about the Internal Revenue Service checks. They stated the resident was provided with an account statement in July 2024, but the updated statement reflecting the new funds would be distributed to the resident next week as part of the regular statement distribution process. During a follow-up interview conducted on 12/18/2024, at 11:00 AM the Business Office Manager stated checks from the Internal Revenue Service intended for Resident #162 were deposited into the facility's account, along with funds for other residents. They stated residents received account statements on a quarterly basis. The Business Office Manager stated they could not confirm whether Resident #162 received their quarterly statement in 2023. 10 NYCRR 415.26(h)(5)(i)

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 40686 Based on interview and record review during the recertification survey from 12/11/2024 to 12/18/2024, the facility did not ensure residents had the right to privacy when sending and receiving mail. This was evident for 15 (Resident #s 150, 202, 248, 246, 370, 126, 146, 185, 15, 181, 133, 22, 205, 162, and 51) of 15 resident in attendance at the Resident Council Meeting. Specifically, Resident #s 150, 202, 248, 246, 370, 126, 146, 185, 15, 181, 133, 22, 205, 162, and 51 reported they did not have the right to personal privacy because the facility staff opened residents' mail delivered to the facility before allowing the mail to be distributed to the resident. The findings are: The facility policy titled Mail dated 05/2024 documented residents were allowed to communicate privately with individuals of their choice and may send and receive personal mail unopened unless otherwise advised by the attending physician and documented in the residents' medical records. The facility policy titled Resident Rights dated 6/2024 documented federal and state laws guarantee the resident's right to communicate in person and by mail, email, and telephone with privacy. The facility Admission Agreement documented the following provisions: the Resident and Resident Representative agree to cooperate with the Facility by signing all necessary documents so that future income of the Resident be mailed directly to the Facility . Such written authorization shall include authorization to open the Resident's personal financial mail . The Resident and/or Resident Representative understand that the physical and mental condition of the Resident may require them to have assistance in opening, reading, and understanding contents of mail. The Resident and Resident Representative consent to . the Facility's opening the Resident's financial mail to assist Resident and for payment purposes. During the Resident Council meeting held on 12/11/2024 at 2:00 PM, all attendees, Resident #s 150, 202, 248, 246, 370, 126, 146, 185, 15, 181, 133, 22, 205, 162, and 51, reported receiving mail that was opened by facility staff prior to being delivered to the resident. During an interview on 12/17/2024 at 12:50 PM, the Activities Director stated they were responsible for distributing mail to residents. The Security Director was the first to receive the mail delivered to the facility and provided the Activities Director with the mail to be delivered to the residents. The Activities Director stated they did not open any mail before delivering it to the residents. The Activities Director stated they have previously received mail that was opened before being given to the Activities Director for distribution. The opened resident mail usually had a written note indicating the resident could now receive the item addressed to them. The Activities Director stated they did not know who was responsible for opening personal ail addressed to residents before residents received the mail. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/17/2024 at 1:00 PM, the Security Director stated they received the mail as it was delivered to the facility and was responsible for sorting the mail into resident personal mail that the Activities Director distributed to residents, resident's bills and insurance correspondence was compiled and given to the Long Term Care Business Office Coordinator, and mail addressed to residents containing checks payable to the resident were given to the Business Office Manager. During an interview on 12/17/2024 at 1:20 PM, the Long Term Care Business Office Coordinator stated mail addressed to a resident in relation to the resident's personal finances, health insurance, bills, and checks and/or funds was not delivered to the resident and was given to the Business Office to be opened and addressed. During an interview on 12/18/2024 at 11:00 AM, the Business Office Manager stated the facility still received paper checks payable to the resident in the mail on a monthly basis from the Social Security Administration. These checks were managed by the Business Office for the resident and were delivered to the Business Office Manager instead of being delivered directly to the resident. On 12/18/2024 at 4:57 PM, the Administrator was interviewed and stated resident's mail was delivered unopened and the facility ensured resident correspondence was kept private and confidential. The Administrator stated they were unaware the facility's Admission Agreement stipulated the facility could open mail addressed to the resident. 10 NYCRR 413.3(e)(1)(ii)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on record review and interview conducted during the recertification survey from 12/11/2024 to 12/18/2024, the facility did not ensure a resident's right to be free of misappropriation of their property. This was evident for 1 (Resident #162) of 2 residents reviewed for personal funds. Specifically, tax return checks mailed to Resident #162 were taken by the facility Business Office without the resident's knowledge or consent and deposited into the facility's bank account. The findings are: The undated facility policy titled Prevention/Identification and Reporting of Patient Abuse documented misappropriation of resident's property was defined as wrongful temporary or permanent use of a resident's money without the resident's consent. The facility policy titled Personal Needs Accounts/Resident Fund Account dated 5/2024 documented all residents have the option to open a Personal Needs Account at any time during their stay, funded by the patient, and intended strictly for their personal use. Resident #162 was admitted with diagnoses including right leg above the knee amputation, depression, and post-traumatic stress disorder. The Annual Minimum Data Set 3.0 assessment dated [DATE] documented Resident #162 was cognitively intact. During the Resident Council Meeting held on 12/11/2024 at 2:00 pm, Resident #162 reported the facility opened mail addressed to Resident #162, and deposited 2 tax refund checks into an account managed by the facility without obtaining the resident's prior authorization to do so. On 12/13/2024 at 11:01 AM, a follow-up interview was conducted with Resident #162 who stated they expected their tax return checks to arrive in the mail and contacted the Internal Revenue Service when no correspondence/checks was received. The Internal Revenue Service informed Resident #162 a check issued in 7/2023 for $1825.02 and a second check issued in 6/2024 for $1957.42 were both made out to Resident #162, mailed to Resident #162 at the facililty, and were deposited into a facility account. Resident #162 stated they managed their own finances since admission to the facility in 1/2020, did not endorse their tax return checks to the facility, did not provide consent for the facility to deposit and manage their personal funds, was not notified when their mail/personal funds arrived a the facility, and was not aware the facility deposited their funds into a facility account until they spoke with the Internal Revenue Service. Resident #162 stated they filed a request with the Internal Revenue Service for their tax return checks from 2023 and 2024 to be reissued because they still did not have possession of their personal funds. Resident #162 stated the Business Office Manager told the resident that they should have attempted to resolve their missing checks with the Business Office instead of filing a claim with the Internal Revenue Service. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility email correspondence dated 12/17/2024 at 10:51 AM including the Administrator, Business Office Manager, and Long Term Care Business Office Coordinator as recipients documented the facility deposited a tax refund check paid to the order of Resident #162 in 7/2023 for $1825.02. The email documented Resident #162 was issued another tax refund check in 6/2024 for $1957.42 but did not document the status or location of the second check. Digital images of a tax refund check dated 7/28/2023 and another tax refund check dated 6/24/2024 were included in the body of the email. Both checks from the United States Treasury were paid to the order of Resident #162. The email did not document or provide a digital image of who endorsed either check for Resident #162. The facility Resident Funds Ledger documented Resident #162's Funds account received its first deposit on 8/31/2023 and a second deposit on 7/31/2024. The Resident Funds Ledger documented a different facility name, did not document the location or name of the bank managing the resident's funds. The Ledger did not document the account number or transaction details, or a digital signature for the person responsible for inputting the Ledger information. Upon multiple requests for bank account statements, transaction history and details, and any other financial information related to Resident #162's tax return checks, the facility was unable to provide any further documentation. There was no documented evidence Resident #162 consented to having their tax return checks deposited into a facility bank account. During an interview on 12/16/2024 at 1:25 PM and 12/18/2024 at 11:00 AM and 11:48 AM, the Business Office Manager stated Resident #162 handled and managed their own finances and personal funds since their admission to the facility and did not consent, written or otherwise, to have their income or personal funds deposited in an account managed by the facility. The Business Office Manager stated Resident #162 expressed concern but the Business Office Manager was unable to explain how tax return checks mailed to Resident #162 were not delivered to the resident and, instead, were deposited in a facility bank account without Resident #162's knowledge, consent, or endorsement. The Business Office Manager stated they were not involved in depositing Resident #162's checks and did not know who was responsible for retrieving the resident's checks from the mail or which facility staff were authorized to perform banking transactions on behalf of the facility. The Business Office Manager stated they were responsible for managing resident personal needs accounts, providing quarterly statements to resident detailing their account information, and providing residents with money from their personal funds accounts upon request. The Business Office Manager was unable to provide any documentation related to detailed transaction history on Resident #162's funds and stated they could not provide any information or statement/record of the financial institution where Resident #162's funds were located. On 12/16/2024 at 1:30 PM, the Long-Term Care and Business Office Coordinator was interviewed and stated mail delivered to the facility was sorted by Security and the Business Office received any mail addressed to residents that contained financial information or checks payable to a resident. The Business Office opened the residents' mail and deposited any checks made payable to a resident into an account managed by the facility. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/2024 at 4:57 PM, the Administrator was interviewed and stated they were hired by the facility in 5/2024 and was not involved in or aware of the Business Office bookkeeping and accounting principles or the procedures used to manage and safeguard resident personal needs accounts. Residents mail should not be opened without the resident's knowledge or consent. The Administrator stated they were unaware Resident #162 had concerns related to unauthorized deposits of their tax refund checks by the Business Office after mail addressed to Resident #162 was opened without their knowledge or consent. The Administrator stated they don't know what happened to the resident's personal funds and would look into it. 10 NYCRR 415.4(b) 48850

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50816 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00354189) surveys from 12/11/2024 to 12/18/2024, the facility did not ensure all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency. Specifically, a resident-to-resident altercation involving Resident #42 and Resident #273 on 9/12/24 at 2:50 PM was not reported to the State Survey Agency until 9/12/24 at 6:17 PM. The findings are: The facility policy titled Abuse, Neglect, Exploitation Prevention & Elderly Justice Act updated 01//2024 documented the New York State Department of Health/Nursing Home Complaint Hotline was to be called to report any physical altercations, alleged abuse. neglect and/or mistreatment and injury of unknown origin. Calls must be placed within indicated time frame to prevent the facility being cited for non-compliance with Reporting. The Elder Justice Act requires nursing homes to report all residents' altercations. The time frame for reporting is 2 hours if there is bodily injury. The Accident/Incident Report with a date and time of occurrence 9/12/2024 at 2:50 PM documented an altercation between Resident #42 and Resident #273 on the 2nd floor elevator. Summary of investigation documented Resident #42 was calm and quiet while visiting a friend on the 2nd floor prior to the incident. Resident #273 was on the 2nd floor elevator to go to a dialysis session. Resident #42 tried to enter the elevator quietly when Resident #273 stopped them. This appeared to have aggravated Resident #42 and triggered a heated verbal exchange which abruptly escalated to physical altercation. Staff immediately intervened; the altercation was deescalated as both residents were brought back to their respective units. Resident #273 presented with slight blood from a cut on the lip and complained of pain on the right scapula. The physician was notified and ordered treatment to the affected lip and x-ray of the right scapula. Resident #273 refused hospitalization and was too upset to go to dialysis. Resident #42 was transferred to the hospital for evaluation as per physician order. Resident # 42 was admitted with diagnoses including but not limited to Schizophrenia, Depression, and dementia. The Minimum Data Set assessment dated [DATE] documented Resident #42 had moderate cognitive impairment, was ambulatory with use of a walker. Resident #273 was admitted with diagnoses including but not limited to End Stage Renal Disease requiring hemodialysis, Chronic Obstructive Pulmonary Disease and anxiety disorder. The Minimum Data Set assessment dated [DATE] documented Resident #273 was cognitively intact, and dependent with wheelchair use. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview on 12/18/24 11:39 AM the Director of Nursing, stated they were notified of the incident on 9/12/24 at around 2:50 PM and reported at 6:17 PM. The incident resulted in a bloody lip to one of the residents, the other was sent out for a psychiatric evaluation, and the police were notified. The Director of Nursing stated they were aware of the need to report the incident within 2 hours and should have reported sooner. 10 NYCRR 415.4(b)(2)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey from 12/11/2024 to 12/18/2024, the facility did not ensure an admission policy was established and implemented that did not require a resident representative to pay for facility care without incurring personal financial liability, and did not require residents to waive their rights and facility liability for losses of personal property. This was evident for 11 out of 11 residents reviewed for Admission. Specifically, 1) Resident #s 162, 268, 229, 90, 259, 175, 194, 108, 212, 211, and 182 were provided Admission Agreements that identified the facility as a non smoking facility, required the Resident Representative to assume all responsibility for the resident, hold the facility harmless for injury, death, and loss of property, and required the Resident Representative to be personally liable for payment of charges incurred by the resident. Additionally,the Admission Agreement documented residents and Resident Representatives agreed to have any future resident income mailed directly to the facility and the facility had authorization to open the resident's financial mail, 2) Resident #108 and #259 were moderately cognitively impaired at the time the facility obtained their signatures on Admission Agreements, and 3) the facility provided an electronically signed Admission Agreement for Resident #162 and the resident denied receiving or signing an Admission Agreement. The findings are: The facility policy titled Resident Rights dated 6/2024 documented federal and state laws guarantee the resident's right to exercise their rights as a resident or citizen of the United States, be supported by the facility in exercising their rights, manage their personal funds, and communicate in person and by mail, email, and telephone with privacy. 1) The Facility Survey Report dated 12/11/2024 documented the facility developed admission policies 3/2022 which specifically state the criteria used in making admission decisions. The Admission Agreement was last amended 9/2022. On 12/11/2024 at 10:26 AM, the Entrance Conference was held with the facility Administrator. A sample of the facility Admissions Agreement was requested and received. (continued on next page)

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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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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The sample Admission Agreement documented Resident Representative will assume certain legal and fiduciary responsibilities by virtue of signing or co-signing this agreement which, if breached, may cause the Resident Representative to become personally liable for payment of charges incurred by the Resident . The Facility shall not be responsible for personal property of any nature including valuables and money which is lost, damaged, stolen, or destroyed including with respect to any loss or damage to the Resident's dentures . If there is loss or damage to property, or injury or death to persons, which is mutually agreed to be or determined by an appropriate third party to be caused solely by the Resident, the Resident agrees to be responsible for the damage, injury, or death . The Resident and Resident Representative assume all responsibility for the Resident the Resident's personal property and hereby release and agree to hold harmless the Facility, its Board of Directors, officers, agents, and employees from any and all responsibilities for the welfare of the Resident, for injury or death, or for damage or loss to any personal property . The Resident and Resident Representative agree to cooperate with the Facility by signing all necessary documents so that future income of the Resident be mailed directly to the Facility . Such written authorization shall include . authorization to open the Resident's personal financial mail . By initialing below, you are agreeing to allow the facility to become representative payee for direct deposit purposes . If the Resident cannot fully understand the management of financial affairs ., the Resident may authorize the Facility to establish an individual trust fund account for the Resident's monies, income, and other funds . The Resident and/or Resident Representative understand that the physical and mental condition of the Resident may require them to have assistance in opening, reading, and understanding contents of mail. The Resident and Resident Representative consent to . the Facility's opening the Resident's financial mail to assist Resident and for payment purposes . 'Smoke free facility.' The Resident agrees that under no circumstances will they smoke anywhere on the grounds or in the building . Acknowledgement - The Attachments, Policies and Notices hereto and for which my signature is applicable include: Authorization for the Establishment of Resident Accounts, Resident Responsibilities, Financial Agent's Personal Agreement for the Benefit of Resident, Consent to Withdraw Funds from Personal Needs Account to Maintain Medicaid Eligibility, Authorization for Assistance with mail and Communications, Binding Arbitration Agreement, Notice of Privacy Practices and Acknowledgement. 2) Resident #108 was admitted to the facility on [DATE] diagnosed with medically complex conditions and dementia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #108 had moderately impaired cognition. The family participated in the assessment and the family provided discharge status information for the resident. The Admission Agreement was electronically signed by Resident #108 on 8/1/2024. There was no documented evidence Resident #108 understood the Admission Agreement they electronically signed due to cognitive status, clinical condition, and family involvement at the time of electronic signature. Resident #259 was admitted to the facility 9/24/2024 with diagnoses of medically complex conditions, depression, and post-traumatic stress disorder. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #259 had moderately impaired cognition, difficulty communicating some words or finishing thoughts, sometimes understood others by responding adequately to simple, direct communication only, and displayed wandering behavior that placed the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility). The resident and Family participated in the assessment and the Family provided information regarding Resident #259's discharge status. The Admission Agreement was electronically signed by Resident #259 on 9/25/2024. There was no documented evidence Resident #259 understood the Admission Agreement they electronically signed due to cognitive impairments and communication difficulties. 3) Resident #162 had diagnoses of right leg above the knee amputation and post-traumatic stress disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #259 was cognitively intact and found it very important to take care of their personal belongings and to have their family or close friend involved in discussions about their care. Resident #162 participated in the assessment and set their overall goals. The Admission Agreement made the 7th day of January 2020 was electronically signed by Resident #162 on 10/25/2024. Resident #162 was interviewed on 12/13/2024 at 11:10 AM and stated they never signed an Admission Agreement with the facility. Resident #162 stated they did not know how their electronic signature was present on an Admission Agreement dated 10/25/2024, was never provided with a copy of the Admission Agreement explaining their rights and responsibilities as a resident of the facility, and never consented to the facility managing their Supplemental Security Income. Resident #162 denied electronically initialing the Admission Agreement giving the facility permission to retain their personal funds and become Representative Payee for direct deposit purposes. Resident #162 stated they have been a resident of the facility for 4 years and have always managed their own finances and did not want the facility managing their money. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/18/2024 at 04:44 PM, the Admission Concierge was interviewed and stated they were responsible for reviewing Admission Agreements with newly admitted residents and signing as witness that the Resident and/or the Resident Representative understood and consented to the facility stipulations. The Director of Admissions was responsible for determining resident capacity to sign the Admission Agreement. The Admissions Concierge stated they did not assess nor were they aware of a resident's cognitive status. The Director of Admissions communicated to the Admissions Concierge which residents they could meet with to explain and obtain their signature on the Admission Agreement. The Admissions Concierge reviewed the Admissions Agreement with the Resident Representative or the Social Worker if the resident lacked the capacity to understand the Admissions Agreement. The contents of the Admission Agreement were read aloud to the Residents and/or the Resident Representatives from a computer tablet screen and a copy of the signed document was provided only upon request. The facility changed their method of obtaining signatures on Admission Agreements in 3/2024 and began using the electronic medical record to electronically sign the Admission Agreement on behalf of the resident or their representative. Residents and/or the Resident Representative were asked whether the resident's income would be retained by the facility. Most short-term residents declined to have their income managed by the facility; however, long-term residents of the facility usually agreed to have their income managed by the facility. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/17/2024 at 12:00 PM and 12/18/2024 at 4:57 PM , the Administrator was interviewed and stated they did not provide accurate information during the Entrance Conference when asked whether residents were asked to enter into binding arbitration agreements. The Administrator initially denied the facility offered binding arbitration agreements; however, the facility's Admission Agreement sample contained an attachment with the terms of a binding arbitration agreement. The Administrator stated they were hired by the facility in 5/2024 and they were not involved in the Admission Agreement revisions that most recently occurred in 3/2024. The facility's legal department was responsible for the terms of the Admission Agreement. The Administrator stated they were aware there were regulatory requirements related to Admission Agreements, resident rights, and facility responsibilities when managing resident financial accounts. The Administrator stated they were unaware the Admissions Agreement detailed the facility's right to open a resident's mail, that resident representatives may be held personally liable for a resident's debts owed to the facility, or that the facility be held harmless for any resident's missing personal property. The Administrator stated the Admission Agreement's smoke-free statement was erroneous and the persons responsible for amending the facility's Admission Agreement used a template from another facility in their corporation and did not revise the agreement to reflect this facility's unique characteristics. The Administrator stated they were unaware the Admission Agreement attachment titled Notice of Federal Privacy Practices documented the facility's disclosure of resident protected health information to business associates and for research purposes, power to deny a resident's request to stop sharing their protected health information, and the right to change the provisions of and apply those amended terms to any protected health information in their possession. The Administrator stated they did not know when the facility began using electronic signatures to sign Admissions Agreements, did not know the computer program used to create the resident's electronic signatures, how they were unique to each resident, or the security measures in place to verify identity. The Administrator stated they were not involved in implementing the electronic signatures and did not know the facility policy or procedure. The Administrator stated the facility no longer obtained individual signatures for each of the Admission Agreement's supplemental attachments providing residents with options to allow facility management of their finances, binding arbitration, information on disclosure practices related to protected health information, and consent for the facility to open a resident's mail without their knowledge. Once the resident electronically signs the main Admission Agreement, they do not sign any other forms because the Admission Agreement contains a statement that by signing, the resident agrees that their signature applies to all other attachments included in the Admission Agreement. The Administrator stated, depending on the type of cognitive loss a resident experienced, a resident with moderately impaired cognitive might be able to understand the legal terminology and facility practices outlined in the Admission Agreement. The Social Workers were responsible for assessing a resident's cognitive status and coordinated with the Director of Admissions to ensure residents approached by the Admissions Concierge had the capacity to understand the Admissions Agreement. The Administrator stated they did not know the method of communication between the Social Workers and the Director of Admissions. The Administrator stated they were unaware of the details regarding Resident #162's tax return checks that were not delivered to the resident upon arrival to the facility and how the checks were deposited into the facility's account without the resident's signature, consent, or knowledge. The Administrator stated they would have to look into Resident #162's claim that they did not sign the Admission Agreement on file as of 10/25/2024 and that the resident never consented to facility management of their finances. 10 NYCRR 415.3(b)(1-8)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00352882) survey from 12/11/2024 to 12/18/2024, the facility did not ensure a resident's representative was notified in writing of a resident's facility initiated discharge. This was evident for 1 (Resident #255) of 5 residents reviewed for Discharge. Specifically, Resident #255 received a Notice of Discharge on 12/16/2024 and there was no documented evidence that a copy of the discharge notice was not sent to the resident representative. The findings are: The facility policy titled Transfer or Discharge Notice dated 6/2024 documented the resident and/or representative will be notified in writing of the reason for the resident's transfer or discharge. Resident #255 had diagnoses of medically complex conditions and depression. The Quarterly Minimum Data Set assessment dated [DATE] documented esident #255 was cognitively intact, required supervision for transfers, ambulationg, resident/family were involved in assessment, a discharge plan was in place, overall goal was return to community, no referrals were requested. On 12/11/2024 at 11:19 AM, the Ombudsman was interviewed and stated their office had concerns with the facility's discharge notification process. The facility received reports from residents that a Notice of Discharge had been issued and the Ombudsman's office had not received a copy of the notice from the facility. A Discharge Notice dated 12/16/2024 documented the interdisciplinary team determined Resident #255 would be discharged to the community on 1/15/2025. The resident's health improved sufficiently so the resident no longer needed the services provided by the facility as evidenced by completion of subacute rehabilitation and exhaustion of Medicare coverage. On 12/17/2024 at 9:25 AM, the Ombudsman stated during a telephone interview that Resident #255 originally received a Notice of Discharge on 12/13/2024 from the Social Worker and the Ombudsman's Office did not simultaneously receive a copy of the notice. Resident #255 contacted the Ombudsman's Office yesterday and reported the Social Worker gave them a revised copy of the discharge notice. On 12/17/2024 at 1:18 PM, Resident #255 was interviewed and stated they received a Notice of Discharge from the Social Worker and was not in agreement with the facility-initiated discharge plan. Resident #255 stated the address on the Notice of Discharge was incorrect and listed their daughter's address which was only Resident #255's mailing address and not their residence in the community. Resident #255 stated they did not discuss the Notice of Discharge with their daughter. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/2024 at 1:32 PM, Social Worker #1 was interviewed and stated they issued a revised Notice of Discharge to Resident #255 on 12/16/2024 and emailed a copy of the notice to the Ombudsman's Office. Social Worker #1 spoke with Resident #255's daughter on previous occasions and did verify that Resident #255's community address was still available. Social Worker #1 was unable to contact Resident #255's daughter to inform them of the Notice of Discharge and to discuss specific discharge plans for Resident #255 to return to the community. Social Worker #1 stated they sent a copy of the Notice of Discharge to Resident #255's daughter via regular uncertified mail and had no documented evidence of the mailing. On 2/18/2024 at 4:57 PM, the Administrator was interviewed and stated the Social Worker provided a Notice of Discharge to the resident, Ombudsman, and the resident's representative. The Administrator stated there was no documented evidence the notices were mailed to resident representatives. The Administrator stated they were involved in the interdisciplinary team discussions regarding resident discharges and was aware of the Notice of Discharge issued to Resident #255 on 12/16/2024. 10 NYCRR 415.3(i)(1)(iii)(a-c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 43478 Based on record review and interview conducted during the recertification and abbreviated (NY00336283) survey from 12/11/2024 to 12/18/2024, the facility did not ensure that Minimum Data Set 3.0 Assessments accurately reflected the residents' status. This was evident for 1 (Resident #276) of 10 residents reviewed for Pressure Ulcers, 1 (Resident #217) of 6 residents reviewed for Accidents, and 1 (Resident #320) of 5 residents reviewed for Discharge. Specifically, 1) the Minimum Data Set 3.0 assessment inaccurately documented that Resident #276's facility acquired pressure ulcer and facility acquired deep tissue injury were present on admission 2) the Minimum Data Set 3.0 assessments did not identify Resident #217 as an active smoker, and 3) Resident #320 had a facility-initiated discharge to the community and the Discharge Minimum Data Set 3.0 assessment inaccurately documented the resident was discharged to a short-term general hospital. The findings are: The undated facility policy, Minimum Data Set guideline for completion documented the facility will ensure accurate and timely completion of Minimum Data Set/Care Plan for all residents in accordance with the Federal and State Operations Manual. All members of the interdisciplinary team are responsible for reviewing all resident strengths, problems needs and plan of care. 1) Resident #276 had diagnoses including but not limited to dysarthria (difficulty with speech), dementia, and cerebral vascular accident (stroke). The 7/6/2023 Admission Minimum Data Set (resident assessment) documented Resident #276 had no pressure ulcers or wounds. The 10/6/2023 Quarterly Minimum Data Set documented Resident #276 had no pressure ulcers or wounds. The 1/6/2024 Quarterly Minimum Data Set documented Resident #276 had no pressure ulcers or wounds. The 3/13/2024 Minimum Data Set discharge assessment documented Resident #276 had 1 unstageable pressure ulcer present on admission and 1 deep tissue injury present on admission. 40686 2) Resident #217 had diagnoses of diabetes mellitus and chronic obstructive pulmonary disease. The 8/9/24 Care Plan related to smoking documented Resident #217 was a known smoker and would be educated on the risks of smoking. The 8/9/24 Nursing Note documented Resident #217 requested to smoke in the morning. The 8/15/24 Quarterly Minimum Data Set was not coded to indicate if Resident #217 was an active smoker at the time of assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #320 had diagnoses of diabetes mellitus, trigeminal neuralgia, and cervical disc disorder. The Social Work Note dated 10/22/2024 documented Resident #320 was provided with the address of a homeless shelter and was informed their discharge date from the facility would be 11/10/2024. The Social Work Note dated 11/6/2024 documented Resident #320 was discharged from the facility and provided transportation to the airport. The Minimum Data Set, dated dated dated MDS 11/6/24 documented Resident #320 was discharged to the hospital. On 12/17/2024 at 1:43 PM during an interview, the Minimum Data Set Director reviewed the Minimum Data Set 3.0 discharge assessment for Resident #276 dated 3/13/2024 and stated the resident's wounds were not present on admission, the assessment incorrectly coded the resident as having the wounds upon admission to the facility, and the assessment required modification to accurately describe Resident #276's condition. The Minimum Data Set Director stated the assessors in their department were responsible for inputting resident clinical data and reviewing the assessments for completion and accuracy prior to assessment transmission and submission. On 12/18/2024 at 4:57 PM, the Administrator was interviewed and stated they were unaware Minimum Data Set Assessments were submitted with inaccurate resident information. The discharge assessment for Resident #320 was inaccurate because Resident #320 was served a 30-day discharge notice and was discharged to the community, not a acute-care hospital. They stated the assessors obtained information by referring to resident's medical records, and any discrepancies on the Minimum Data Set assessments were unintentional mistakes. 10 NYCRR 415.11(b)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 43478 Based on record review and interview conducted during the recertification and abbreviated survey (NY 00344069) from 12/11/24 to 12/18/24, the facility did not ensure each resident was provided with the necessary care and services to ensure the resident's ability to communicate their needs to staff was available. This was evident for 1 of 2 residents (Resident #275) reviewed for communication. Specifically, Resident #275 who spoke Spanish as their primary language was not provided with a Spanish translator as indicated in the resident's Care Plan. Additionally, the staff did not know how to access a translation device or services. The findings are: The policy titled Communication/Language documented make every effort to provide interpretive services for residents whose primary language is other than English. The facility staff will strive to ensure meaningful language access and communication services are available for all limited English proficient persons. Resources available for language access service during hours of facility operation, include the following: a)Language Access Vendor o Telephonic Interpreting Services/Video Remote Interpreting Services. b) Communicative Devices/Language Communication Boards are available on Units. Resident #275 had diagnoses including cerebral infarct (stroke), diabetes mellitus, and muscle weakness. The 5/31/24 Baseline Care Plan documented Resident #275 could communicate easily with staff, understood staff, wanted an interpreter to communicate with a doctor or health care staff, and their primary language was Spanish. The 6/1/24 Care Plan titled Resident has an Interpretation Need documented the resident would communicate via an interpreter and the resident's preferred language was Spanish. The 6/3/24 Medicare-5 day Minimum Data Set (resident assessment) documented Resident #275 had intact cognition, adequate hearing and clear speech, was able to make themselves understood and understood others. The resident and family participated in the assessment. On 12/17/24 at 12:21 PM during an interview, the Director of Nursing stated that only during one evening, the Certified Nurse Aide who provided care to the resident was proficient in speaking Spanish. The Director of Nursing stated the other Certified Nurse Aides who provided care to the resident were not proficient in speaking Spanish. The Director of Nursing stated they were unsure whether the Certified Nurse Aide instructions documented the resident's need for interpretive services. On 12/17/24 at 1:58 PM during a follow-up interview, the Director of Nursing stated the Certified Nurse Aide instructions for Resident # 275 did not document the resident was Spanish speaking and required interpretive services or devices. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 3:41 PM during an interview, Certified Nurse Aide #2 stated if a resident was Spanish speaking, it was not documented on the Certified Nurse Aide instructions. They stated there were not enough Spanish speaking Certified Nurse Aides to provide care to all the Spanish speaking residents. They stated they had not been in-serviced on using the language translation devices. On 12/17/24 at 4:07 PM during an interview, Certified Nurse Aide #4 stated they provided care to the resident. They stated they were not proficient in Spanish. They stated there was no information on the Certified Nurse Aide Instructions to inform the aides whether residents were Spanish speaking or instructions on how to communicate with Spanish speaking residents. They stated they asked a Spanish speaking Certified Nurse Aide to translate as needed. They stated they had not been in-serviced on using language translation devices. On 12/18/24 at 9:56 AM during an interview, the Administrator stated the nurse was responsible for making the Certified Nurse Aide assignments. They stated the nurse should weigh all priorities equally when making assignments. They stated Spanish speaking was only one of the priorities taken into consideration. 10 NYCRR 415.12(a)(c)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on observation, record review, and interview during the recertification and abbreviated (NY00336283) surveys from 12/11/24 to 12/18/24, the facility did not ensure residents at risk for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, and prevent new ulcers from developing for 2 of 10 residents (Residents #276 and #115) reviewed for Pressure Ulcers. Specifically, 1) for Resident #276 at risk for skin breakdown there was no documented evidence that preventative measures as per care plan and the use of heel booties as per the 1/30/24 physician order were implemented prior to the development of a 2/9/24 left heel pressure ulcer and 3/1/24 left dorsal foot deep tissue injury and 2) Resident #115's air mattress pressure was not inflated according to the Resident's weight. The findings are: The Policy and Procedure titled Pressure Injury Prevention and Management dated 5/2024 documented a resident who enters the facility without pressure injury does not develop pressure injury unless individuals clinical condition demonstrates they were unavoidable. It is the responsibility of the facility staff via the interdisciplinary team to recognize any resident who is at risk for pressure ulcer development and initiate appropriate preventive measures. The Air Mattress Support Surface Policy revised on 6/2024 documented ensure that residents who have need for bed redistributing support surfaces to promote comfort, prevent skin breakdown, promote circulation and provide pressure relief or reduction will receive treatment as ordered. A physician's order is required for the use of an air mattress, use the pressure adjustable knob to give maximum resident comfort based on the resident's weight in pounds (lbs.) as applicable, air pressure inflation monitoring should be checked and documented on the Treatment Administration Record by nurses each shift. 1) Resident #276 had diagnoses including but not limited to dysarthria (difficulty with speech), dementia, and cerebral vascular accident. The 6/30/23 Care Plan, Resident is dependent on staff daily in meeting ADL needs with admitting diagnoses of activity intolerance, impaired balance, limited mobility, and stroke. Interventions included to provide 2-person dependent assistance with bed mobility. The 6/30/23 Care Plan Potential Impaired Skin Integrity: Resident is at risk of developing impaired skin integrity as evidenced by undocumented Braden score, bladder and bowel incontinence, impaired mobility, cognitive deficits, non-ambulatory status, and functional decline. Interventions included to turn and reposition every 2-3 hours. The 10/19/23 Nursing Braden Scale for Predicting Pressure Sore Risk Assessments score of 17 documented Resident #276 was at risk for skin breakdown. The December 2023/January 2024 Point of Care Audit Reports (Certified Nurse Aide documentation) did not provide documented evidence of turning and repositioning or off-loading Resident #276's heels. (continued on next page)

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Hudson Hill Center for Rehabilitation & Nursing	65 Ashburton Avenue Yonkers, NY 10701

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/4/24 Nursing Braden Scale for Predicting Pressure Sore Risk Assessments score of 17 documented Resident #276 was at risk for skin breakdown. The 1/6/24 Quarterly Minimum Data Set (resident assessment) documented Resident #276 had severely impaired cognition, limitations in range of motion to upper extremity on one side and lower extremities on both sides, required substantial/maximal assistance with rolling left and right and had no pressure ulcers or wounds. The 1/1/24 through 1/29/24 Progress Notes did not include documentation of preventive measures taken to address the resident's risk for skin breakdown. The Physician order documented 1/30/24 heel booties. The January and February 2024 Treatment Administration Records did not provide documented evidence of turning and repositioning, heel booties, or off-loading Resident #276's heels. The 2/2/24 Weekly Wound Rounds/Team Assessment Medical Note documented left heel scab, date of onset 2/1/24, measurements: length 2.0, width 1.0, depth 0. Wound bed 100% dry scab. Recommended Primary Dressing: Skin Prep with bordered gauze daily and prn. The 3/1/24 Weekly Wound Rounds/Team Assessment Medical Note documented: 1) unstageable pressure injury of the left heel, date of onset 2/2/24, length 4.0, width 4.0, depth undetermined. wound bed 50% eschar, 50% blister. Recommended primary dressing: betadine and bordered gauze daily and prn. 2) pressure injury-deep tissue injury to left dorsal foot. date of onset 3/1/24. length 3.0, width 2.5, depth 0. wound bed 50% eschar, 50% blister. Recommended primary dressing: dry protective dressing daily and prn. The 3/13/24 Minimum Data Set (resident assessment) discharge assessment documented Resident #276 had 1 unstageable pressure ulcer and 1 deep tissue injury. On 12/16/24 at 6:05 PM during an interview, Registered Nurse Supervisor #1 stated heel booties were ordered [DATE], 2 days prior to identification of the left heel scab. Registered Nurse Supervisor #1 reviewed the Point of Care Audit Reports (Certified Nurse Aide documentation) and stated there was no documented evidence that turning and repositioning or offloading Resident #276's heels occurred in December 2023 or January 2024. Registered Nurse Supervisor #1 stated there was no documented evidence of Resident #276 having been provided an air mattress. Registered Nurse Supervisor #1 stated there were no documented interventions in place to prevent skin breakdown on the Certified Nurse Aide tasks. They stated turning and positioning was documented in the Potential Impaired Skin IntegrityCare Plan, but it was not documented in the Certified Nurse Aide tasks or on the Treatment Administration Record. Registered Nurse Supervisor #1 stated that turning and positioning should have been documented in the Certified Nurse Aide tasks. On 12/16/24 at 6:23 PM during an interview, the Director of Nursing stated interventions for pressure ulcer prevention should have been in place to prevent skin breakdown such as heel booties, turning and repositioning, off loading, and/or air mattress, but the interventions were not in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24 at 1:24 PM during an interview, the Wound Nurse stated Resident #276 had no wounds prior to February 2, 2024. The Wound Nurse stated no interventions were documented to prevent skin breakdown. The Wound Nurse stated that heel booties were ordered on 1/30/24, but that was only 2 days prior to the reported left heel scab, and would not have been sufficient to prevent the scab from developing in the 2 day time period. The Wound Nurse stated that the unit managers were responsible to enter orders for skin breakdown prevention. The Wound Nurse stated that the Registered Nurse Unit Manager who performed the Braden Assessment on 1/4/24 should have initiated and implemented interventions to prevent skin breakdown based on the Braden Score of 17 which documented that Resident #276 was at risk for skin breakdown. The Wound Nurse stated Resident #276 developed 2 wounds on the left foot at the facility, and both wounds were avoidable. On 12/18/24 at 10:40 AM during an interview, the Wound Care Physician stated it was possible that Resident #276's left heel and left dorsal foot wounds could have been avoided if off-loading or heel booties or turning and repositioning or an air mattress had been in place. The wound care physician stated that preventive interventions should have been in place, since the resident was at risk for skin breakdown. 50816 2) Resident #115 had diagnoses including chronic obstructive pulmonary disease, unspecified dementia and Alzheimer's disease. The 9/13/24 Braden Scale for Predicting Pressure Ulcer Risk Assessment score of 14 documented Resident # 115 was at risk for skin breakdown. The 10/05/2024 Care Plan titled Impaired Skin Integrity Pressure Ulcer/Injury documented the resident had impaired skin integrity as evidenced by a Stage 3 pressure injury on the left heel. The Physician Order dated 11/23/24, documented skin checks every day shift, Hydrogel external gel (wound dressing) apply to left heel Stage 3 topically every evening shift for wound care. Cleanse with normal saline, pat dry, apply hydrogel, calcium alginate and cover with foam dressing. The Minimum Data Set (resident assessment tool) dated 11/28/2024, documented Resident # 115 had severely impaired cognitive skills, was dependent on staff for activities of daily living, at risk of developing pressure ulcer, had a Stage 3 pressure ulcer, and had a pressure reducing device for the bed. The 12/06/2024 weight record documented Resident #115 weight was 181.0 pounds. The Physician Order dated 12/13/24 documented air mattress. During observation on 12/12/24 at 8:57 AM, 12/13/2024 at 9:24 AM and 12/27/2024 at 9:18 AM, Resident # 115 was in bed, the air mattress was on and the dial was set at 350 pounds. There is no documented evidence in the December 2024 Treatment Administration Record that the air pressure inflation monitoring was checked. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/17/24 at 09:21 AM Certified Nursing Assistant #11, stated the Maintenance Department took care of the air mattress and the resident was weighed during the first week of the month. During an interview on 12/17/24 at 10:35 AM Registered Nurse #7 stated they did not check the air mattress dial. During an interview and observation on 12/17/24 at 10:44 AM, in Resident #115's room with the Director of Nursing and Registered Nurse #7, the Director of Nursing checked the air mattress dial and stated the dial was set at 350 pounds. The Director of Nursing asked Registered Nurse #7 to check the weight of Resident #115 in the electronic health record. Registered Nurse #7 checked the weight and stated the resident's weight was 181 pounds. The Director of Nursing stated they were unable to provide documentation that the air mattress was checked and documented by nurses each shift in the Treatment Administration Record as per facility policy. 10NYCRR 415.12(c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 40686 Based on observation, interview and record review conducted during an abbreviated survey (NY00348967), the facility did not provide person-centered care and services necessary to maintain the highest practicable physical, mental, and psychosocial well-being for one of six residents (Resident #271) reviewed for Accidents. Specifically for Resident # 271 with a history of pneumonitis due to inhalation of food/vomit and dysphagia the facility did not develop and/or implement a plan to address the resident's individual needs and minimize risk of potential choking hazards as per [DATE] hospital visit summary swallowing recommendations for a soft, bite-sized diet texture, mildly thick liquids with no straw, and intermittent supervision to monitor for aspiration and after Resident #271 verbalized a [DATE] request for chopped texture proteins due to difficulty with chewing chicken and beef. Additionally, the facility did not thoroughly investigate an incident to rule out choking after Resident #271 was found unresponsive in their room on [DATE] after being served their lunch meal tray. The findings are: The policy titled Accidents and Incidents Investigating and Reporting dated ,d+[DATE] documented all accidents or incidents involving residents shall be investigated using the Report of Incident/Accident Form including the circumstances surrounding the accident or incident, the names of witnesses and their accounts, and other pertinent data as necessary or required. The facility policy titled Aspiration Precautions dated ,d+[DATE] documented aspiration precautions were defined as measures taken to reduce the risk of aspiration during eating, drinking, and other activities. Nursing staff were responsible for monitoring residents for signs of aspiration risk, implementing precautions and communicating changes in condition. Speech Language Pathologists assess swallowing function and recommend appropriate dietary modifications and interventions. Provide direct supervision for residents with high aspiration risk and observe for signs of difficulty such as coughing and choking. Documents observations in the resident's medical record. Resident #271 had diagnoses of cerebral infarction with left hemiplegia and hemiparesis, aphasia, and dysarthria. The Hospital Visit Summary dated [DATE] documented Resident #271 had a speech language pathology clinical swallowing evaluation on [DATE]. The evaluation documented Resident #271 had a past medical history of pneumonitis due to inhalation of food and vomit and dysphagia. The swallowing recommendations were for Resident #271 to receive a soft, bite-sized diet texture, mildly thick liquids with no straw, and intermittent supervision to monitor for aspiration. Physician Orders dated [DATE] documented Resident #271 was ordered to be placed on aspiration precaution and receive a regular texture diet with thin liquids. A Speech Language Pathology Screen dated [DATE] and [DATE] documented Resident #271 was ordered regularly textured food consistency with thin liquids, was not on a mechanically altered diet, and was recommended to receive speech-language services. A swallowing evaluation was not recommended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Speech Therapy Note dated [DATE], [DATE], and [DATE] documented Resident #271 presented with dysarthria, residual aphasia, was edentulous, and the goal of therapy was to improve speech intelligibility by improving coordination of phonation and speech respiration. Resident #271 swallowing function and diet consistency were not documented. A neurological status care plan initiated [DATE] documented Resident #271's diet be adjusted to accommodate chewing, swallowing, or eating issues to maximized independence and nutritional intake. A care plan related to poor oral hygiene initiated [DATE] documented Resident #271 was edentulous, and interventions included providing consulting with the dietician and Speech to change the resident's diet if the resident presented with chewing/swallowing problems. A speech therapy care plan dated [DATE] documented Resident #271 received a speech/language evaluation and treatment for cognition/speech/language. A care plan related to Resident #271's risk for aspiration dated [DATE] documented interventions including monitoring for signs and symptoms of coughing and choking, providing regular meals with thickener and ensuring adequate hydration and nutrition. A risk of malnutrition care plan dated [DATE] documented Resident #271 had varying oral intake and a recent hospitalization . Interventions to maintain adequate nutritional intake included monitoring and recording the resident's intake and monitoring and documenting as needed signs and symptoms of dysphagia, pocketing, choking coughing, drooling, holding food in mouth, or several attempts as swallowing. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #271 had mild cognitive impairments, had no difficulty chewing, required setup assistance with eating, did not receive speech therapy services in the 7 days prior to assessment, did not receive a mechanically altered diet, and did not display symptoms of a swallowing disorder. The Dietary Note dated [DATE] documented Resident #271 verbalized experiencing difficulty with chewing chicken and beef as well as coughing when drinking thin liquids. Resident #271 requested chopped texture protein, mashed potato instead of rice, and nectar thick liquids. The registered nurse supervisor and director of rehabilitation were made aware. There was no documented evidence the Speech Language Pathologist evaluated Resident #271 after [DATE]. Nursing Notes following [DATE] Dietary Note did not document Resident #271's oral intake and/or difficulty swallowing or eating. The Physician's Order dated [DATE] documented Resident #271's diet order was changed to regular texture with honey consistency liquids. The Certified Nursing Assistant Kardex Report as of [DATE] documented instructions to monitor Resident #271 and document and report as needed any signs and symptoms of dysphagia, pocketing, choking, coughing, holding food in the mouth, or several attempts at swallowing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Certified Nursing Assistant Accountability Record for June and [DATE] documented Resident #271 was provided with eating setup and/or clean up during meals. There was no documented evidence Resident #271's meal intake was monitored and recorded. There was no documented evidence the Certified Nursing Assistant Accountability Record for [DATE] and [DATE] that nursing staff monitored Resident #271 for signs and symptoms of dysphagia. The Treatment Administration Record for June and [DATE] documented Resident #271 was on aspiration precautions. The record did not require nursing staff signatures to verify aspiration precautions were provided to Resident #271. The [DATE] Complaint Tracking System intake NY 00348067 documented the facility reported at 12:50 PM, Resident #271 was found unresponsive in their room after being served their lunch meal tray, cardiopulmonary resuscitation was performed, and Resident #271 expired at 1:30 PM. The facility investigation was ongoing to rule out choking episode as the resident did not have any incident of having difficulty swallowing previously. The Investigative Report dated [DATE] documented Resident #271's cause of death was cardiopulmonary arrest. The statements from staff and summary did not document whether Resident #271 ate any portion of their lunch meal, if the resident had any food items in their mouth or airway and did not rule out aspiration as a possible contributing factor to Resident #271's cause of death. . On [DATE] at 3:22 PM, the Dietary Technician was interviewed and stated they were responsible for the resident's food preferences and assessments upon admission and readmission. The Registered Dietician can write diet orders but the Registered Dietician for the facility was away on vacation and on leave and not available. The Dietary Technician input the resident's food preferences into the kitchen menu system but does not input the consistency and texture of the diets. The Dietary Technician did not have a documented communication form or system with the registered Dietician. They communicated verbally regarding resident preferences or concerns related to diet orders. The Dietary Technician did not communicate with the Medical Doctors related to resident diets and only communicated with the nurses on the unit. The Dietary Technician stated they were not able to downgrade or change a resident's diet consistency in the kitchen menu system. The Speech Therapist was responsible for changing a resident's diet consistency and would communicate with a resident's aspiration precautions through a group chat for facility staff. Resident #271 reported to the Dietary Technician they had difficulty swallowing and requested their chicken and beef be cut into small pieces. The Dietary Technician stated they wrote their note during the weekend, manually wrote the resident's diet preference on their meal ticket for that evening, verbally told the Registered Nurse and the Director of Rehabilitation about the resident's need for a Speech Therapy evaluation, and texted the Speech Therapist, who was on vacation at the time. The Dietary Technician visited with Resident #271 a few days later and the resident appeared fine. The Dietary Technician did not follow up with the nursing staff to ensure a Speech Therapy evaluation was ordered and did not follow up with the Director of Rehabilitation. The Dietary Technician did not document their follow up with the resident in their notes and did not check the resident's chart to ensure a change in diet consistency was ordered. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 01:10 PM, the Speech Therapist stated they were responsible for overseeing resident diet orders and communicating any change in a resident's consistency to the kitchen and nursing staff. They assess residents for clinical signs of aspiration risk. Nursing staff can downgrade a diet for a resident if they are expressing or observed with difficulty in managing the diet texture they currently received. The Speech Therapist stated they were responsible for assessing and screening new admissions for cognitive function and speech function to determine and whether they can benefit from services. The Speech Therapist stated they usually assess new admission within 24 hours of their admission to the facility. They checked diet orders and any speech language referrals or recommendations from the hospital. The Speech Therapist stated they evaluated Resident #271 upon admission and must have missed the diet order for soft foods and thickened liquids from the hospital. The Speech Therapist stated they would have followed the order from the hospital and recommendations. Resident #271 was assessed on [DATE] and the Speech Therapist stated they determined the resident could tolerate the regular texture diet they were consuming for the 2 days since their admission to the facility. The Speech Therapist stated they did not receive any referrals or requested to see Resident #271 since discontinuing them from services in ,d+[DATE]. They were not aware that Resident #271 had any difficulties with managing their diet consistency. On [DATE] at 12:58 PM, Registered Nurse #36 was interviewed and stated resident #271 did not experience any difficulty with chewing their food or choking during their morning meal on [DATE]. Resident #271 was in their room and Registered Nurse #36 stated they checked the resident's blood sugar prior to lunch and the resident was stable with no concerns. Registered Nurse #36 had their diet consistency changed to thickened liquids but had a regular texture diet and did not express to the Registered Nurses that they had difficulty with their current regular texture diet. A resident on aspiration precautions should eat in the floor dayroom and be supervised by staff. The floor dayroom was closed due to renovations and all residents had to eat in their rooms during ,d+[DATE]. The nursing staff were instructed to round more regularly on residents who were on aspiration precautions to monitor and supervise residents for eating difficulties. On [DATE] at 1:38 PM, Certified Nursing Assistant #34 was interviewed and stated they found Resident #271 unresponsive when they went to their room to pick up the resident's lunch tray. Certified Nursing Assistant #34 stated they did not observe any food in or around the resident's mouth or on the resident's bed. They did not observe any signs of vomiting or drooling, and the meal tray appeared untouched. Certified Nursing Assistant #34 stated they were made aware of aspiration precautions by the nurse and rounded on residents more often during mealtime if the residents ate in their room. On [DATE] at 2:20 PM, the Director of Nursing was interviewed and stated they were unaware Resident #271 had a diagnosis of dysphagia on their Hospital Discharge Summary and that the hospital Speech Pathologist recommended a soft, bite-sized diet texture. The Director of Nursing stated they reviewed the Dietician's note regarding Resident #271's request for a downgraded diet and determined the Dietician did not communicate this information to the Registered Nurse or the Director of Rehabilitation to ensure Resident #271 received a Speech Therapy evaluation for downgraded diet texture. The Director of Nursing stated they were not aware that staff statements and their Investigative Report did not include information related to whether Resident #271 aspirated during the lunch meal. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:18 PM, Medical Doctor #1 was interviewed and stated they were Resident #271's attending physician and completed the resident's death certificate. Medical Doctor #1 stated they recall the nurse who reported the resident's death via telephone told Medical Doctor #1 that Resident #271 choked during the lunch meal on a piece of chicken. Medical Doctor #1 stated they did not include this as a cause of death and did not personally assess the resident upon their death on [DATE]. Medical Doctor #1 stated they did find the report concerning and reported it to someone in the nursing office but could not recall who they spoke with. Medical Doctor #1 stated they did not document the nurse's verbal report in the resident's medical record. Medical Doctor #1 stated they did not follow up with the Director of Nursing to ensure the issue was investigated. Medical Doctor #1 stated they did not know the Dietician recommended for a Speech Therapy evaluation or that Resident #271 requested downgraded diet consistency due to difficulty swallowing on [DATE]. 10 NYCRR 415.12(h)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255 Based on observation, record review and interview during the recertification survey from 12/11/24 to 12/18/2024, the facility did not ensure each resident received necessary respiratory care in accordance with professional standards of practice and as ordered by the practitioner for 3 (Resident #168, Resident #194, and Resident #69) of 6 residents reviewed for respiratory care. Specifically, 1) Resident #168 was observed tracheostomy self-suctioning without a physician order, 2) Resident #194 with a physician order for 3 and/or 5 liters of continuous oxygen was observed receiving 7 and/or 8 liters of oxygen and 3) for Resident #69 there was no documented evidence to indicate the oxygen tubing/cannula were being changed. The findings are: The policy and procedure titled Oxygen Administration with a 5/2024 revision date documented, the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure, oxygen therapy is administered by way of oxygen mask, non-rebreather oxygen mask, nasal cannula. equipment and supplies will be necessary when performing the procedure - oxygen concentrator, nasal cannula. Oxygen tubing will be changed as ordered and as needed and tubing will be dated to indicate last date of tubing change. 1) Resident #168 was admitted to the facility with diagnoses including but not limited to respiratory failure, schizophrenia, and bipolar disorder. The Physician Order documented 8/21/24 tracheostomy care every shift, and 10/24/24 oxygen via tracheostomy mask continuous 2-3 Liters/minute. There was no documented physician order for Resident #168 to self-suction their tracheostomy. The Quarterly Minimum Data Set (resident assessment tool) dated 11/7/24 documented, Resident # 168 was cognitively intact, had a tracheostomy and received oxygen therapy. The December 2024 Treatment Administration Record documented suction tracheostomy as needed and was not signed off by staff as completed. There was no documented evidence in Nursing and Respiratory Therapy Progress Notes that Resident # 168 was evaluated for ability to perform tracheostomy self-suctioning. During an observation on 12/12/24 at 9:53 AM Resident # 168 was resting in bed with 2 Liters of oxygen via tracheostomy mask. Resident #168 pulled the suction catheter, which was hanging freely without a cover, inserted the suction catheter to the tracheostomy site and performed self-suctioning. After completion of self-suctioning, Resident #168 placed the suction catheter over the nightstand. Resident #168 stated prior to facility admission they knew how to suction their tracheostomy. They stated after they were admitted a respiratory therapist observed and approved their self-suctioning. Resident #168 stated they could not remember the name of the therapist. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/13/24 at 3:39 PM Registered Nurse #6 stated only nurses performed tracheostomy suctioning. They stated respiratory therapy assessed the residents monthly. Registered Nurse #6 stated some time ago they observed Resident #168 performing tracheostomy suctioning, but they could not remember exactly when. Registered Nurse #6 stated they told the resident they were not allowed to perform self-suctioning, and reported this to Respiratory Therapy. Registered Nurse #6 stated they documented the situation but were unable to find the documentation. During an interview on 12/16/24 at 10:52 AM, the Director of Nursing stated they did not know of any residents who could perform tracheostomy self-suctioning, and staff had not reported Resident #168 was self suctioning. 2) Resident #194 was admitted to the facility with diagnoses including but not limited to respiratory failure, cerebrovascular accident, quadriplegia. The Quarterly Minimum Data Set, dated dated dated [DATE] documented, Resident # 194 had severe cognitive impairment, a tracheostomy and received oxygen therapy. The Physician Order dated 12/9/24 and December 2024 Medication Administration Record documented oxygen 3 liters continuous via tracheostomy. During observation on 12/13/24 at 3:16 PM, Resident #194 was in the bed receiving oxygen 8 liters via tracheostomy. The Medical Administration Record was signed by Registered Nurse #16 on 12/13/24 for administration of oxygen continuous via tracheostomy at 3 Liters. The Physician Order dated 12/16/24 and December 2024 Medication Administration Record documented continuous oxygen via tracheostomy mask at 5 liters/minute. During observation on 12/18/24 at 10:29 AM Resident #194 was in the bed, receiving oxygen 7 liters via tracheostomy. Registered Nurse Unit Manager #6 looked at the oxygen concentrator display and stated the oxygen concentrator was delivering 7 liters of oxygen. They stated this oxygen flow was incorrect and should have been delivered at 5 liters. They stated they did not know why the oxygen flow rate was administered incorrectly. 50816 3) Resident #69 had diagnoses including chronic obstructive pulmonary disease, encephalopathy, and acute kidney failure. The Minimum Data Set, dated dated dated [DATE] documented Resident #69 had severely impaired cognitive skills, shortness of breath when lying flat, and was on continuous oxygen therapy. The Physician's Order dated 11/22/2024 documented continuous 2 Liters of oxygen every shift for chronic obstructive pulmonary disease. The Physician's order dated 12/13/2024 documented change oxygen device nasal cannula every 7 days and as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan dated 11/24/2024 documented the resident had oxygen therapy related to respiratory illness, administer oxygen continuously by mask/cannula at 3 Liters per minute, There was no intervention to change the tubing. During observations on 12/12/24 at 9:02 AM and on 12/13/2024 at 12:37 PM, Resident # 69 was observed in bed, asleep with oxygen via nasal cannula. The nasal cannula oxygen tubing had no date. During an interview and observation on 12/13/24 at 3:43 PM Registered Nurse #7 stated the resident was on continuous oxygen. Registered Nurse #7 stated the facility protocol on oxygen therapy consisted of checking the order every shift and changing/labeling the cannula every 3 days by the night shift. Registered Nurse #7 observed the nasal cannula tubing and stated the tubing was not dated. Registered Nurse #7 further stated they had no idea when the oxygen tubing was last changed as it was not dated. 10 NYCRR 415.12(k) (6)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on interview and record review conducted during the recertification and abbreviated (NY 00348067) survey from 12/11/2024 to 12/18/2024, the facility did not ensure the physician reviewed the resident's total program of care, including medications and treatments, at each visit. This was evident for 1 (Resident #271) of 6 residents reviewed for Accidents. Specifically, Medical Doctor #1 did not review and document a hospital Speech Pathology dysphagia diagnosis and diet texture recommendations for Resident #271 and did not review a Dietician note documenting Resident #271 had difficulty eating a regular texture diet. The findings are: The facility policy titled Aspiration Precaution dated 5/2024 documented the interdisciplinary team will collaborate and develop a personalized care plan documenting the resident's dietary recommendations and supervision needs. Resident #271 had diagnoses of cerebral infarction with left hemiplegia and hemiparesis, aphasia, and dysarthria. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #271 had mild cognitive impairments, required setup assistance with eating, did not receive speech therapy services, did not receive a mechanically altered diet, and did not display symptoms of a swallowing disorder. The Hospital After Visit Summary dated 3/25/2024 documented Resident #271 had a speech language pathology clinical swallowing evaluation on 3/18/2024. The evaluation documented Resident #271 had a past medical history of pneumonitis due to inhalation of food and vomit and dysphagia. The swallowing recommendations were for Resident #271 to receive a soft, bite-sized diet texture, mildly thick liquids with no straw, and intermittent supervision to monitor for aspiration. Physician Orders dated 3/25/2024 documented Resident #271 was ordered to be placed on aspiration precaution and receive a regular texture diet with thin liquids. The Admission Medical Evaluation dated 3/26/2024 documented Resident #271 had medically complex conditions and slurred speech. The Evaluations did not document Resident #271's history of dysphagia and diet recommendations from the hospital. A Dietary Note dated 6/28/2024 documented Resident #271 verbalized experiencing difficulty with chewing chicken and beef as well as coughing when drinking thin liquids. Resident #271 requested chopped texture protein, mashed potato instead of rice, and nectar thick liquids. The registered nurse supervisor and director of rehabilitation were made aware. The Medical Doctor Note dated 6/29/2024 documented Resident #271 was assessed for loose bowel movements. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order dated 7/2/2024 documented Resident #271's diet order was changed to regular texture with honey consistency liquids. There was no documented evidence the Medical Doctor reviewed and addressed Resident #271's total plan of care at each visit to address their diagnosis of dysphagia and difficulty chewing. On 12/18/2024 at 1:18 PM, Medical Doctor #1 was interviewed and stated they were Resident #271's attending physician and did not know the Dietician recommended for a Speech Therapy evaluation or that Resident #271 requested downgraded diet consistency due to difficulty swallowing on 6/28/2024. Medical Doctor #1 stated they only reviewed hospital discharge paperwork in relation to medication orders and did not pay attention to nutrition/diet orders. Medical Doctor #1 stated they did not review the Dietician's notes and relied on the nurse to provide them with the necessary information to determine resident treatment plans. On 12/18/2024 at 3:26 PM, the Medical Director was interviewed and stated they follow up with Medical Doctors almost daily. Medical Doctor #1 should have reviewed the Resident #271's medical record when assessing the resident and should have taken nutrition and Dietician notes into account when evaluating and determining the resident's plan of care. 10 NYCRR 415.15(b)(2)(iii)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 50766 Based on interview and record review conducted during a recertification survey conducted from 12/11/24 to 12/18/24, the facility did not ensure that each resident received the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being for one (Resident #220) of four residents reviewed for mental health services. Specifically, a psychology consult for Resident #220 was not conducted as per physician order. The findings are: The Policy titled Consultations, dated 5/24. documented medical consultations services provided in the facility are completed by the medical staff that has been approved by the credentialing process outline in the medical staff by-laws. Resident #220 was admitted with diagnoses including acute stress reaction, uncomplicated alcohol dependence, uncomplicated cocaine abuse. The Care Plan (dated 8/9/23 and revised 9/23/24) titled Recent Right Leg Amputation (accident or injury) documented encourage expression of fears, negative feelings, and grief over the loss of body part. Help the amputee cope with altered body image. The Care Plan (dated 8/10/23 and revised 9/23/24) titled Psychosocial Well-Being documented potential for abuse related to (specify), allow resident to express feelings of being anxious, as necessary. The Quarterly Minimum Data Set (a resident assessment tool) dated 11/12/24 documented Resident #220 had intact cognition, felt down, depressed or hopeless, had trouble with concentrating, had no behavior concerns, was not on antipsychotic medication and had medically complex conditions. The Physician Order dated 1/29/24 documented psychology consult, one time only for 30 days. The Psychiatry Consult Note dated 02/02/24 documented psychology consult recommended. Patient would benefit from regular therapy. Patient monitored for any psychiatric or behavioral issues. The Psychiatry Consult Note dated 11/12/24 documented psychology consult recommended. Patient would benefit from regular therapy. Patient monitored for any psychiatric or behavioral issues, Referral for psychology services as requested by the patient. During an interview on 12/12/24 at 10:50 AM Resident #220 stated they had visits with the psychiatrist while in facility. Resident #220 stated they requested a psychology therapist to talk to regarding past traumas including loss of parent/s, homelessness and being hit by a train, resulting in a lost limb. Resident #220 stated the psychiatrist agreed to a psychology visit and would request for Resident # 220 to be seen by psychology. Resident #220 stated they had not received a psychology consultation. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 12/17/24 at 04:08 PM the Director of Nursing stated they could not locate a completed psychology consult report, after reviewing Resident #220's electronic medical record. At that time the Director of Nursing contacted the Registered Nurse/ Unit Manager #2 who was also unable to locate a psychology consult report in Resident #220's unit paper chart. The Director of Nursing stated the consultant psychologist visited residents as requested. The Director of Nursing stated they were not aware if the consultant psychologist visited Resident #220 and stated they are not able to provide documentation that a psychology consult was completed. During an interview on 12/18/24 at 11:07 AM Registered Nurse/Unit Two Manager #28, stated they did not recall Resident #220 having a recent psychology consult. They stated they were aware of orders for a psychology consult in the past and were aware there was a recent psychiatry recommendation for a psychology consult. They stated they discussed the recommended psychology consult with administration during morning meetings in November 2024 and was told by administration that the psychologist visits the facility on the weekends. They stated Resident #220 requested to see a psychologist and that information was brought to the attention of the administrator. During an interview on 12/18/24 03:38 PM the Consultant Psychologist stated they conducted psychology referrals and followed residents at the facility. They stated they provided psychology services for the facility for about two years and had a current roster of approximately 20 visits per month. They stated they did not receive a referral for Resident #220 and did not recall consulting with Resident #220. 10 NYCRR 415.12(f)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51647 Based on observation, record review and interview conducted during the recertification survey from 12/11/24 to 12/18/24, the facility did not ensure all drugs and/or biologicals in 1 of 3 medication storage rooms and 1 of 6 medication carts were labeled and stored in accordance with professional standards. Specifically, an insulin pen, (Lantus Solostar 100 units) for Resident #93 with a use by date of 11/6/24 remained in the refrigerator on unit 4 and a controlled medication (Phenobarbital) remained in the locked drawer of the moveable medication cart on unit 4. The findings are: The policy titled Medication Storage in the Facility with a revision date of June 24 documented outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from the stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy if a current order exists. Controlled medications following the medication pass are returned to the double locked cabinet, in a timely manner. Controlled medications are never left in between medication passes in the medication cart. The policy titled Insulin Storage and Labeling with a revision date of June 24 documented insulin vials and pens should be discarded after 28 days or per manufacturer/supplier recommendations. During an observation on 12/13/24 at 10:41 AM, an insulin pen, (Lantus Solostar 100 units) for Resident #93 with an open date of 9/10/24, and a use by date of 11/6/24 remained in the unit 4 medication storage room refrigerator. During an interview on 12/13/24 at 10:43 AM Registered Nurse Unit Manager #6 stated they and the nurses checked the refrigerator daily for expired medications. Registered Nurse Unit Manager #6 stated Resident #93 had an insulin pen in the cart, so they were not sure why the opened insulin pen was in the refrigerator. Registered Nurse Unit Manager #6 stated insulin pens that were past the use by date were supposed to be removed from the area. During an observation on 12/13/24 at 10:50 AM a blister pack containing 27 pills of a controlled drug (Phenobarbital 64.8 mg) remained in the locked drawer of the moveable medication cart on unit 4. The medication cart was in the hall by the nurses station. During an interview on 12/13/24 at 10:50 AM Registered Nurse #21 stated the Phenobarbital was last given at 9 pm, the night before. Registered Nurse #21 stated most times they kept the medication in the cart. Registered Nurse #21 stated the locked medication cart stayed in the hall by the nursing station. During an observation on 12/13/24 at 11:02 AM, Registered Nurse #16, Licensed Practical Nurse #23, and Registered Nurse Unit Manager #6 tried to open the controlled medication box in the medication storage room on unit 4 using the keys, but were unsuccessful. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/13/24 at 11:02 AM Registered Nurse #16 and Licensed Practical Nurse #23 stated they could not open the controlled medication box in the medication room. They stated they kept controlled medications in the medication cart. During an interview on 12/13/24 at 11:03 AM Registered Nurse Unit Manager #6 stated nurses kept the controlled medication in the medication cart but were not supposed to. During an interview on 12/13/24 at 11:14 AM the Director of Nursing stated expired medications should be discharged right away by any of the nurses on the unit. They stated any Licensed Nurse should report to the supervisor if they found expired medications. The Director of Nursing stated medication storage rooms were to be checked daily by the Registered Nurse Unit Manager. The Director of Nursing stated controlled medications should be returned to the medication room after each shift and no controlled medication that was not being used for the shift should be in the medication cart. The Director of Nursing stated it was the supervisor's responsibility to check and make sure controlled medications were returned to the medication storage room during each shift. During an interview on 12/16/24 at 10:05 AM the Pharmacy Consultant Supervisor stated the last audit of the medication carts and storage rooms was in December. They stated the unit refrigerator was inspected during the December audit. They stated they were not responsible for discarding expired medications. The Pharmacy Consultant Supervisor stated they notified the nurse who was there during the audit of any findings. They stated if they found anything expired, they would pull it from the cart and/or refrigerator and the nurses were responsible for discarding it. They stated they believed when they pulled the medication maybe the nurse did not properly discard, and the oncoming nurse put it back into the refrigerator. 10 NYCRR 415.18(e)(1-4)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 40686 Based on observation, interview, and record review conducted during the recertification survey from 12/11/2024 to 12/18/2024, the facility did not ensure residents and their representatives were explicitly informed of their right not to sign an arbitration agreement as a condition of admission to the facility. This was evident for 2 of 3 (Residents 211, and 182) residents reviewed for Arbitration. Specifically, facility Admission Agreements for Resident #211, and #182 included language that the resident and/or resident representative signature was applicable to a Binding Arbitration Agreement (an attached document included in the Admission Packet). The findings are: The facility Admission Packet included an Admission Agreement and a list of Attachments that included a Binding Arbitration Agreement. The Admission Agreement documented the Attachments, Policies, and Notices here to and for which my signature is applicable include: . Attachment 16 - Binding Arbitration Agreement. Admission Packets for Resident #211 signed by the resident and undated, and #182 signed by the resident representative and undated, were reviewed and documented the resident and/or representative signature was applicable to all attachments to the Admission Agreement including the Binding Arbitration Agreement. There was no documented evidence residents were given the option to sign an Admission Agreement to the facility without consenting to the facility's Binding Arbitration Agreement. On 12/11/2024 at 10:27 AM, the entrance conference was held with the Administrator who stated the facility did not offer binding arbitration agreements to residents and there were no residents that entered into a binding arbitration agreement with the facility. A sample of the facility's Admission Packet was requested. On 12/17/2024 at 12:00 PM, the facility Admission Agreement and Packet was reviewed and contained an attachment and provisions for residents to enter into binding arbitration agreements. The Administrator was interviewed and stated they were not involved with and did not know the contents and rules set forth in the facility's Admission Agreement. The Administrator did not know binding arbitration agreements were offered and would provide a list of residents who chose to sign the arbitration agreement. The Administrator stated the Admission Agreement was a template that was probably used in other facilities that were run by the same corporate entity as this facility. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/2024 at 4:57 PM, the Administrator was interviewed and stated the facility's legal counsel was responsible for determining the terms of the facility's Admission Agreement. The Administrator stated they were unaware of the language in the Admission Agreement that applied the resident and/or representative signature to the attached Binding Arbitration Agreement. The Administrator stated the facility no longer required residents who signed the Admissions Agreement to sign any of the attached documents included in the Admission Packet and was unable to explain how a resident would be able to differentiate their Admission Agreement signature from consent to entering a Binding Arbitration Agreement. 10 NYCRR 415.26

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50766 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00356093) surveys from 12/11/2024 to 12/18/2024, the facility did not ensure an effective pest control program was maintained to ensure the facility was free of pests. This was evident for 3 (2nd, 4th, and 6th Floors) of 5 resident floors reviewed for environment. Specifically, a 2nd floor Resident reported seeing roaches in their room, and roaches were observed on the 4th and 6th Floors. The findings are: The facility policy titled Pest Control dated 6/2024 documented a written agreement with a qualified outside pest service will be maintained to provide comprehensive pest control services utilizing a variety of methods to eradicate and contain household pests, including roaches. There was no documented evidence of a valid Pest Management Contract. The Facility Survey Report and the Facility Assessment, both dated 12/11/2024, did not identify a third-party contractual agreement with a pest control company and did not document pest control as a necessary service to care for residents. During an interview on 12/12/2024 at 12:06 PM, Resident #182 stated there were roaches in their room and bathroom on the 2nd Floor. The resident's representative bought and placed roach traps in the room to address the issue. On 12/12/2024 at 12:35 PM, Resident #152 stated there was a persistent and pervasive roach infestation in their room. The roaches were visible at all times of the day, but the activity worsened at night when the roaches crawled up their privacy curtain and along the walls next to their bed. Resident #152 stated they kept a blue latex glove at their bedside to smash the roaches that crawled near them at night. Resident #152 stated their bedside dresser was overrun with roaches even though they did not keep any food items in their room. Resident #152 stated they had reported the issue to the nursing staff and observed an exterminator come into the room several weeks ago, but the roach activity did not decrease. During the interview, Resident #152's beside dresser was observed without clutter or food items. A large roach quickly darted out of the opened middle drawer, ran down the exterior and disappeared under the dresser. A medium-sized roach was also observed crawling inside the top drawer near the resident's wash basin. Several small roaches were observed on the floor under Resident #152's bed and near the bedside table. The wall near the window in Resident #152's room was observed with a crushed roach approximately 4 feet off the floor. During an interview with Certified Nurse Aide #18 on 12/13/2024 at 02:32 PM in room [ROOM NUMBER], A medium-sized roach was observed crawling on the floor. Certified Nurse Aide #18 killed the roach by stepping on it and stated they previously observed roaches on the 4th Floor, reported the sightings by documenting in the unit's Pest Logbook, and saw an exterminator come to treat the unit. The Pest Logbook for 2nd, 4th, and 6th Floors, reviewed from 12/1/2023 to 12/11/2024, documented there were roaches in all rooms on the 4th Floor. Roach observations were not documented on the 2nd Floor or Resident #152's room on the 6th Floor. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence the facility requested or received recommendations and alternative treatment options from the Pest Management Company for continued roach infestations in the facility. During an interview on 12/17/2024 at 08:48 AM, Certified Nurse Aide #31, assigned to the 2nd Floor, stated there was a significant roach problem in resident rooms, hallways, and dining room. Certified Nurse Aide #31 stated they observed roaches daily and reported their observations to the floor Nurse Manager. Certified Nurse Aide #31 stated they previously saw an exterminator visit the facility but was unable to state how often pest control services were provided to the unit. They stated housekeeping cleaned resident room's daily but sometimes there was 1 Housekeeper for the entire unit. During an interview on 12/17/2024 at 09:13 AM, Housekeeper #32, assigned to the 2nd Floor, stated they observed roaches on the 2nd Floor and throughout the rest of the facility. The roach infestation was difficult to control because some residents kept food in their rooms. Housekeeper #32 stated an exterminator visited the facility and recently there was less roach activity. During an interview on 12/17/2024 at 09:24 AM, Registered Nurse #30, 2nd Floor Nurse Manager, stated they observed roaches in the hallways and nursing station on when working overnight. They stated they documented their observation in the Pest Logbook and the exterminator visited the facility weekly. During an interview on 12/17/2024 at 01:10 PM, the Director of Housekeeping stated the facility worked with a Pest Management Company and an exterminator visited the facility weekly. Reports of pest concerns and observations were documented in the Pest Logbooks on each floor. The Director of Housekeeping met with the exterminator at the conclusion of each facility visit and received a verbal report of the exterminator's activities and recommendations. The Director of Housekeeping stated they met with the Administrator to update them verbally on the exterminator recommendations. Their most recent pest control discussion with Administration took place in 11/2024 and involved terminally cleaning 1 resident room (including dresser drawers, and closets) per day. Housekeeping staff completed a Terminal Cleaning Log for each room they completed. The roach infestation was difficult to control because residents kept food in their rooms and there was ongoing construction in the facility. The Director of Housekeeping was unable to provide documented evidence the Terminal Cleaning Logbook addressed pest infestation concerns, of exterminator meetings and recommendations, and that meetings with Administration took place to review and address exterminator recommendations regarding roach infestation. During an interview on 12/18/2024 at 05:51 PM, the Administrator stated the Pest Management Company treated resident rooms, bombing them, if necessary, when staff identified sightings of pests. Housekeeping staff conducted terminal cleaning of the rooms. Staff educated residents to address behaviors that may contribute to roach infestation. The Administrator stated they conducted visual rounds of resident floors daily and recorded their observations of pests in the Pest Logbook. Housekeeping coordinated with the Pest Management Company and followed up on verbal recommendations. The Administrator stated there was no documented evidence the Pest Management Company provided the facility with recommendations to abate roach infestation or that the facility addressed verbal recommendations with an action plan. 10 NYCRR 415.29(j)(5) (continued on next page)

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	12/18/2024

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40686 49255

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	12/18/2024

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 51647 Based on record review and interview conducted during a recertification survey from 12/11/24 to 12/18/24, the facility did not ensure Certified Nurse Aides were provided the required 12 hours of training and/or annual in-services to ensure safe delivery of care including dementia management and resident abuse prevention training. Specifically, the facility was unable to provide documentation that 5 of 5 Certified Nurse Aides (#22, #24, #25, #26, and #27), were provided dementia management training. Additionally, the facility was unable to provide documentation that Certified Nurse Aide (#27) completed12 hours in-service training, and abuse prevention training. The findings are: The Policy titled Inservice Training with a May 24 review date documented all personnel are required to attend regularly scheduled in-service training classes. The Facility Assessment with a 12/11/24 updated on date documented required in-service training for nurse aides must be sufficient to ensure continuing competence of nurse aides but must be no less than 12 hours per year. It also documented dementia management training and resident abuse prevention training must be included. There was no documented evidence in the 12 hours of annual inservice that Certified Nurse Aide # 22, #24, #25, #26, and #27 received dementia management training. There was no documented evidence Certified Nurse Aide #27 completed the 12 hour in service training and abuse prevention training. During an interview on 12/16/24 at 11:53 AM the Nurse Educator stated they previously worked 5pm-1am once a week but stopped in October 2024. The Nurse Educator stated they planned to work nights in January at which time Certified Nurse Aide #27 would be trained. The Nurse Educator stated they were responsible for training all staff and would try and complete missing dementia training with Certified Nurse Aides #22, #24, #25, #26, and #27. During an interview on 12/16/24 at 12:19 PM the Director of Nursing stated the Nurse Educator previously worked 1 overnight shift 11pm-7am, and 1 weekend shift to ensure all aides and nurses were trained. The Director of Nursing stated they were not aware of missed training's for Certified Nurse Aide #27, but they were aware the overnight staff lacked training in general. 10 NYCRR 415.26 (c)(1)(iv)