

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Hudson Hill Center for Rehabilitation & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 65 Ashburton Avenue Yonkers, NY 10701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interviews during survey, the facility failed to ensure that the residents' environment remained as free of accident hazards as is possible with the use of assistive device for one (1) (Resident #169) of four (4) residents reviewed for accidents. Specifically, the use of a left-enabler bar (bar attached to the bed designed to facilitate movement, improve safety) was not implemented as per physician order for Resident #169, which resulted in a 04/05/2025 fall from bed when Certified Nurse Aide #8 turned Resident #169 onto their left side during care. Subsequently, Resident #169 was transferred to the hospital and diagnosed with a right intertrochanteric (thigh bone) fracture (broken bone). This resulted in actual harm to Resident #169 that was not Immediately Jeopardy. The findings included: The Assessment for enabler bars dated 01/13/2025 completed by the rehabilitation department documented an enabling device is indicated to promote independence. Left-enabler device recommended. Request made to maintenance to install an enabling device. Nursing notified. Resident #169 had diagnoses including obesity (excessive body fat), paraplegia (inability to voluntarily move legs), and generalized weakness. The Physician Order dated 01/14/2025 documented left-enabler bar for bed mobility to aid in turning and positioning on every shift. The Care Plan for enabler-bar dated 01/14/2025 documented may use enabler bars. There was no documented evidence that goals and interventions were added to the Care Plan to address the use of enabler bars prior to 05/06/2025. The admission Minimum Data Set (a resident assessment tool) dated 01/17/2025 documented Resident #169 was cognitively intact, had functional impairment of one (1) upper extremity (arm) and both lower extremities (legs), was dependent with rolling from their back to side and was not at risk for falls. The Accident and Incident form dated 04/05/2025 at 5:30 AM completed by Registered Nurse #21 documented that Resident #169 slipped off the bed when Certified Nurse Aide #8 was turning the resident. Resident #169 had no visible injury but was holding their head in pain and complaining of pain in their lower extremity. Review of the written statement completed by Certified Nurse Aide #8 dated 04/05/2025 documented that they were giving care to the resident. They turned the resident to the left to clean the resident, and the resident started to shake. The right leg slipped down, and the resident fell out of bed. There was no documented evidence on the 04/05/2025 Accident and Incident form that indicated a left enabler bar was in place. There was no documented evidence on the 04/01/2025 - 04/31/2025 Certified Nurse Aide Follow Up Question Report to address the use of a left enabler bar. The Progress Notes dated 04/05/2025 at 6:12 AM by Registered Nurse Supervisor #21 documented the floor nurse called for assistance. The resident had a fall at 5:30 AM. The resident rolled off the bed during care (as per certified nurse aide). The resident was holding their head in pain, with no change in mental status, and no visible injury was noted. The Medical Doctor was notified and ordered a transfer to the emergency room for an X-ray of the head to rule out a head injury. Emergency Medical Services on its way. The Emergency Department Visit (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Summary dated 04/05/2025 documented that Resident #169 had a right intertrochanteric fracture. The Progress Note dated 04/11/2025 at 5:17 PM written by Registered Nurse Supervisor #21 documented the resident was readmitted from the hospital at 3:30 PM. The resident was brought in by ambulance and escorted by two (2) staff members. The resident had been treated for a right hip fracture after a fall and had undergone a surgical procedure with right gamma nailing (internal fixation of fracture). The resident was received in stable condition, alert, and oriented times three (3). The resident had a surgical wound on the right hip region. All orders were carried out, the Medical Doctor was notified, and the resident was made comfortable. The resident was to be continually monitored. The Summary of Investigation dated 04/15/2025 documented Resident #169 was on skilled physical and occupational therapy for therapeutic exercises and activities for activities of daily living training secondary to deconditioning. The resident used a left-enabler bar for bed mobility and was dependent on staff in most areas of activities of daily living. Certified Nurse Aide #8 was interviewed and recounted that they were providing care to the resident when, upon turning the resident to the left side, the resident started to shake, which led to the resident's right leg slipping off the bed, dragging the resident's whole body down to the floor. The resident was sent to the hospital for evaluation. The resident was care planned for one (1)-assist for bed mobility. There was no documented evidence on the 04/15/2026 Summary of Investigation that indicated a left enabler bar was in place. During an interview on 04/10/2026 at 1:43 PM, Physical Therapist #22 stated Resident #169 required substantial/maximum assistance (required 75 percent assistance; could only do a little for themselves). They stated Resident #169 required one (1) assist for bed mobility. During an interview on 04/14/2026 at 3:12 PM, the Director of Nursing stated Resident #169 had a left-enabler bar since January 2025. They stated they signed off on the accident/incident report completed on 04/05/2025 but were not aware if the left-enabler bar was in the up position. They stated they could not say if the left-enabler bar in the up position would have prevented the fall. During a telephone interview on 04/14/2026 at 3:40 PM, the Medical Director/Primary Physician stated they were familiar with Resident #169's condition and they were notified that Resident #169 had a fall that resulted in a hip fracture. They stated the left-enabler bar would have helped Resident #169, but when the resident slid off the bed, their motion was strong, and the resident kept falling. During an interview on 04/13/2026 at 9:34 AM, Resident #169 stated Certified Nurse Aide #8 turned and pushed them over too far. Resident #169 stated they fell on their right hip. They had surgery and had rods/screws placed in the right hip. They stated now they could help with turning because they have side rails, but before the fall they did not have enablers. Resident #169 stated that their condition caused spasms and prevented movement from their waist down. They stated they did not have spasms when they fell. During a telephone interview on 04/13/2026 at 11:49 AM, Certified Nurse Aide #8 stated they were giving Resident #169 peri care and turned the resident to wipe them. Resident #169's leg started to shake, and the resident slid out of the bed very quickly and fell on their right side on the floor. They stated the resident was on their assignment and this was not the first time they had taken care of the resident. They stated the resident needed one (1) assist for care, turning, and positioning. During an interview on 04/13/2026 at 1:20 PM, Registered Nurse #9 stated they were called to Resident #169's room by Certified Nurse Aide #8. They stated Resident #169 was on the floor complaining of a little back pain; no injury was observed, no bleeding, no mental status changes. They stated they called the nursing supervisor. They stated they took the resident's vital signs. They stated they could not recall Resident #169 having bed enablers. They stated the resident fell on the left side of the bed. During an interview on 04/14/2026 at 5:02 PM, the Administrator stated that the enablers on the second-floor beds could not be lowered/raised. They stated that all beds on the second floor were new in April (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2025, and those are the same beds currently on the second floor. All enablers that were in place were fixed and could not be moved without tools. They stated that former Registered Nurse Supervisor #21, who completed the Accident/Incident report form, may not have seen the enabler at the time of the resident's fall, and that it may have been obscured by the mattress. The Administrator stated they reviewed the Accident/Incident Report and signed off on it but did not notice the discrepancy in the documentation regarding the enabler bar.10 NY CRR 415.12 (h)(2)		

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	warm because the lunch trays were delivered to the unit 30 minutes late. During an observation of the lunch tray assembly in the kitchen on 04/14/2026 at 11:42 AM temperatures were taken by the Food Service Director. The temperature of the milk was 47 degrees Fahrenheit. They stated the milk had not been delivered that long ago and possibly had not been in the refrigerator long enough before tray line started. During an interview on 04/07/2026 at 9:44 AM the Food Service Director stated staff had been educated on labeling and dating items that have been opened, and anyone can discard expired foods. They stated they were not sure why the eight (8) cartons of milk were expired when they had just received a delivery. They stated stock was rotated by the stocking staff person, and everything was dated when it was delivered. The Food Service Director stated they were not aware the diet aide was leaving the rack of juice and milk out of the refrigerator while preparing the rack for the tray line. During an interview on 04/07/2026 at 1:11 PM Registered Nurse Unit Manager #20 stated nursing staff was allowed to put their personal food and drinks in the unit pantry refrigerator, but they must be labeled and dated. They stated nursing staff was responsible for logging the refrigerator temperatures, and disposal of expired, unlabeled, and undated food. They stated they were not sure why there were items in the refrigerator that were expired, unlabeled and undated.10 New York Code Rules Regulations 415.14(h)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that the call bell system was accessible for one (1) (Resident #74) of seven (7) residents reviewed for environment. Specifically, the facility did not ensure that Resident's #74's call bell was within reach. Findings include: The policy and procedure titled Call Bell System reviewed 07/2025 documented the facility will ensure that all residents shall have a call bell within reach while in their room. Provide a call bell with long extension to reach the resident's bed. Check to see that call bell is within reach before leaving the room. Resident #74 had diagnoses including legally blind, below knee amputation, and diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #74 had moderately impaired cognition. Resident #74 required supervision with rolling left to right and lying to sitting on side of bed; and partial assistance for toileting, personal hygiene, sit to stand and transfers. A review of the comprehensive care Plan for Falls dated 06/15/2026 documented ensure the call light is within reach and encourage the resident to use it for assistance as needed. During observations on 04/08/2026 at 9:27 AM, 04/09/2026 at 1:03 PM, and 04/10/2026 at 12:07 PM, Resident #74 was sitting on their bed. The call bell was on the floor at the head of the bed and out of the resident's reach. Resident #74 stated they used the call bell to call for assistance but had not had the call bell in a month. Resident #74 stated they just waited for the nursing staff to come into the room and would ask for help. During observation on 04/10/2026 at 12:07 PM Resident #74 was sitting on their bed and asked for a urinal. They stated they knew they had one but could not locate it. The call bell was on the floor at the head of the bed, out of the resident's reach. The surveyor activated the call bell for Resident #74, and Registered Nurse #5 came across the hall and went into Resident #74's room. During an interview and observation on 04/10/2026 at 12:18 PM, Certified Nurse Aide #4 stated they provided cares for Resident #74 that day and had assisted them to get washed and dressed. When the location of the call bell was pointed out to Certified Nurse Aide #4, they stated they typically gave the call bell to Resident #74 and clipped it to the bed sheet by their pillow, but they had been dealing with a lot that morning and must have forgotten to do it. Certified Nurse Aide #4 stated they knew they should always put the resident's call bell within their reach. During an interview on 04/10/2026 at 12:30 PM, Registered Nurse Unit Manager #6 stated call bells should be clipped to the bed sheet by the pillow and checked every shift. They stated they were not sure why Resident #74's call bell was out of reach for three (3) days. They stated they did not notice it when they rounded. During an interview on 04/13/2026 at 11:40 AM the Director of Nursing stated Certified Nurse Aides should make sure call bells were in reach before they left resident rooms. 10 New York Codes Rules and Regulations 415.5(e)(1)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure prompt efforts to resolve grievances for one (1) of five (5) residents (Resident #116) reviewed for personal property. Specifically, there was no documented evidence that a thorough investigation was conducted, and that Resident #116 was compensated for lost clothing that was reported to the facility on [DATE] and 03/02/2026. The findings included: The undated policy titled Grievance, Reporting and Response documented investigate and respond to all Residents' grievances in a timely manner. The Grievance Official or designee will notify the Resident and complainant of the final disposition of the complaint, in writing. Resident #116's diagnoses included other low back pain, type two (2) diabetes mellitus without complications, and pain in the left knee. Review of the Resident Inventory reports dated 06/22/2025, 10/28/2025, 11/06/2025 revealed they were completed by Resident #116. A Grievance Report dated 12/23/2025 documented that the resident made numerous complaints about things missing from their room, clothing going to laundry and not returning, and lack of communication. The resident still has not received any of their belongings or compensation for the losses. Social Worker #14 received the report. Room and floor were searched. Will continue to look. Resident aware. Signed by the Administrator on 12/28/2025. A follow up report dated 03/02/2026 documented the resident reports the following belongings have gone missing since date of admission and other recent items that were collected from their room and taken to laundry. See attached list of belongings. Continue to look for items. Family aware. Signed by the Director of Social Services/Grievance Officer on 03/02/2026. There was no documented evidence that a thorough investigation was conducted and that Resident #116 was compensated for the lost items after the 12/23/2025 and 03/02/2026 report of missing items. There was no documented evidence that Resident #116 was provided written notification of grievance resolution. A quarterly Minimum Data Set (a resident assessment tool) dated 03/29/2026 documented Resident #116 was cognitively intact. During an interview on 04/07/2026 at 12:18 PM, Resident #116 stated Social Worker #14 had been given grievance forms with missing items and that Registered Nurse Unit Manager #3 was also aware of missing items including underwear, bras, night gowns, sweaters, sweatpants and socks. Resident #116 stated when clothing items went to laundry, only some items returned. They stated they did not receive reimbursement for the missing items. They stated they met with the Assistant Administrator and informed them that missing items totaled approximately \$125. They stated the Assistant Administrator told them they could not reimburse for the clothing but could offer Resident #116 some donated clothing. Resident #116 stated they were never shown/provided replacement clothing, reimbursed or provided a written grievance outcome. During an interview on 04/10/2026 at 3:02 PM, Unit Manager Registered Nurse #3 stated they were aware that Resident #116 reported missing clothing that was not returned from laundry. They stated they also reached out to the Housekeeping Director, provided Resident #116 with reassurance and provided Resident #116 with inventory forms. They stated they believe Resident #116's socks and possibly a pair of pants were returned. During an interview of 04/10/2026 at 5:17 PM, the Director of Social Work/Grievance Officer stated that the grievance reports dated 12/23/2025 and 03/02/2026 were incomplete. They stated they did not believe items were found or replaced or that Resident #116 was reimbursed for any of the missing items. They stated they did not have written documentation that Resident #116 received a grievance resolution. During an interview on 04/13/2026 at 11:07 AM, the Assistant Administrator stated they did not recall conversation with (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #116 regarding missing property/clothing.They stated they did not recall that Resident #116 was offered reimbursement or offered donated clothing as replacement. During an interview on 04/13/2026 at 11:13 AM, the Director of Housekeeping stated they believe Resident #116 reported missing items and that some items were returned.They stated they did not recall informing Administration or the Concierge of missing items for Resident #116 but may have. During an interview on 04/14/2026 at 1:57 PM, Social Worker #14 stated for the 12/23/2025 grievance, they filled out the first page and gave it to the Director of Social Work/Grievance Officer and were unaware if anyone investigated or followed up with Resident #116. For the 03/02/2026 follow up grievance, they filled out the first page of Resident #116' s grievance and obtained a list of missing items. They searched Resident #116's room and no items were found. They stated Housekeeping was notified and they discussed the missing items with the Director of Social Work/Grievance Officer. Social Worker #14 stated they could not answer why the investigation or resolution sections of the grievance were not complete. They stated there was one item (socks) that matched Resident #116's inventory sheet and the resident was offered new socks or reimbursement. Resident #116 took the socks and continued to want reimbursement for other missing clothing. 10 New York Codes Rules and Regulations 415.3 (d)(1)(ii)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review the facility failed to ensure that residents are free from restraints for one (1) of one (1) resident (Resident #10) reviewed for restraints. Specifically, there was no documented evidence that a physician order, assessment, consent, and a care plan were in place to address the use of an abdominal binder for Resident #10. The findings included: Resident # 10 had diagnoses including Alzheimer's disease, depression, and adult failure to thrive. The 02/04/2026 Nursing Progress note written by Registered Nurse Manager #6 documented a transfer to hospital summary. The resident was noted to be without their gastrostomy tube in place. The writer and another Registered Nurse attempted reinsertion but were unable to maintain stoma patency. The Nurse Practitioner was notified and ordered that the resident be transferred to the hospital for reinsertion of the gastrostomy tube. The Physician Order dated 02/12/2026 documented 120 mL water flush three times a day (total 360 mL) by gastrostomy tube and enhanced barrier precautions every shift for the gastrostomy tube. The quarterly Minimum Data Set (assessment tool) dated 02/17/2026 documented that Resident #10 had severe cognitive impairment, was dependent on staff to perform their daily living activities and did not use a restraint. There was no documented evidence in the electronic medical record that a physician order, assessment, consent, and a care plan were in place to address the use of an abdominal binder. During an observation on 04/07/2026 at 11:56 A.M., 04/08/2026 at 1:15 P.M., and 04/10/2026 at 8:04 A.M., Resident #10 was resting in bed with an abdominal binder in place. During an interview on 04/10/2026 at 11:45 A.M., Certified Nurse Aide #10 stated they provided care for the resident that morning and had gotten the resident dressed. They stated they put the abdominal binder back on the resident because the resident kept pulling out the gastrostomy tube. They stated the resident had an abdominal binder since they returned from the hospital. During an interview on 04/10/2026 at 11:48 A.M., Licensed Practical Nurse #11 stated the resident had an abdominal binder on, but they did not see a physician's order for the abdominal binder. They stated they did not document it because it was not on the residents' Medication Administration Record. During an interview on 04/10/2026 at 1:08 P.M., the Director of Nursing stated that the facility did not have a restraint policy because it was restraint-free. They stated they were not aware that the resident had an abdominal binder, and if they were aware they would have notified the physician and evaluated whether it was necessary. They stated when the resident removed the gastrostomy tube, the resident was ill. They stated the resident did not need an abdominal binder. During an interview on 04/10/2026 at 3:01 PM, Registered Nurse Supervisor #12 stated that on 02/12/2026 when the resident returned from the hospital, they had an abdominal binder on. They stated there was no physician order for the abdominal binder. They stated the nurse in the hospital informed them to keep the abdominal binder on because the resident might pull out the gastrostomy tube. They stated they were told to remove it after 24 hours. They stated that on 02/13/2026, they removed the abdominal binder and placed it in the resident's closet. They stated they did not want to discard the resident's abdominal binder because it was the resident's personal property. They stated the resident was transferred to the fifth floor on 02/19/2026. 10 New York Code Rules and Regulations 415.4(a) (2-7)		

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NAME OF PROVIDER OR SUPPLIER Hudson Hill Center for Rehabilitation & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 65 Ashburton Avenue Yonkers, NY 10701	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview the facility failed to ensure that the Minimum Data Set assessment 3.0 accurately reflected the resident's status for one (1) of one (Resident #7) reviewed for smoking. Specifically, the 08/28/2025 comprehensive Minimum Data Set assessment was not coded to reflect Resident #7's use of tobacco. The findings included: The policy and procedure titled Minimum Data Set 3.0, revised 10/2024, documented all members of the interdisciplinary team were responsible for reviewing the Minimum Data Set and completing the assigned care area assessments. Additionally, the interdisciplinary team was responsible for reviewing all residents' strengths, problems, needs, and plans of care to ensure the delivery of appropriate and quality care in accordance with facility policies and federal and state guidelines. Resident # 7 had diagnoses including Parkinson's disease, seizure disorder, and chronic obstructive pulmonary disease. The Care Plan for psychosocial history dated 01/05/2025 revealed the resident was a known smoker. The plan directed staff to review the smoking policy with the residents as needed and to allow the resident to smoke in the designated smoking area with supervision. The 08/28/2025 comprehensive Minimum Data Set (an assessment tool) documented that Resident #7 had intact cognition and did not use tobacco. During an observation/interview on 04/09/2026 at 8:30 AM, Resident #7 stated they smoked tobacco, had no issues when smoking, and could hold the cigarettes. During an observation/interview on 4/10/2026 at 10:18 AM, Resident #7 was in the smoking area wearing an apron. The resident was holding a cigarette without difficulty. During an interview on 4/13/2026 at 03:55 PM, Minimum Data Set Coordinator #1 stated the resident's annual Minimum Data Set was completed on 08/28/2025; they also stated that section J was not captured for tobacco use. They stated they did not receive the smoking list from the activities department and missed coding the tobacco use section as yes.10 New York Code Rules Regulations 415.11(b)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that comprehensive care plans were reviewed and revised to reflect the current code status for two (2) of two (2) residents (Resident #7 and Resident #101) reviewed for advance directives. Specifically, 1) there was no documented evidence that advance directive care plans were reviewed and care plan interventions updated to accurately reflect cardiopulmonary resuscitation status for Resident #7 as per physician order and 2) there was no documented evidence that advance directive care plans were reviewed and care plan interventions updated to accurately reflect cardiopulmonary resuscitation status for Resident #101 as per physician order. The findings included: The Policy and Procedure for advanced directive, revised 05/2025 documented the facility will honor the wishes of the resident/representative regarding medical concern, by honoring the existing advanced directives of the residents. Physicians' orders are required for advanced directives, including full code; Social Services will evaluate and create a care plan for advanced directives. 1. Resident # 7 had diagnoses including Parkinson's disease, depression, and chronic obstructive pulmonary disease. The Care Plan for advanced directive dated 08/31/2023 documented full code with interventions to ensure a copy of do not resuscitate is on the resident's chart, ensure a do not resuscitate sticker is prominently displayed in the chart, and ensure that a do not resuscitate/non-hospital/do not resuscitate form is transferred with resident to hospital/clinic offices/out on pass. The Physician Order dated 10/21/2025 documented cardiopulmonary resuscitation The quarterly Minimum Data Set (an assessment tool) dated 12/30/2025 documented that Resident # 7 had intact cognition. 2. Resident #101 had diagnoses including schizoaffective disorder, depression, and anemia. The Physician Order dated 05/16/2022 documented cardiopulmonary resuscitation. The Care Plan for advanced directive dated 06/20/2023 documented full code with interventions to ensure a copy of do not resuscitate is on the resident's chart, ensure a do not resuscitate sticker is prominently displayed in chart, and ensure that a do not resuscitate/non-hospital do not resuscitate form is transferred with the resident to hospital/clinic offices/out on pass. The quarterly Minimum Data Set, dated [DATE] documented Resident #101 had moderate cognitive impairment. During an interview on 04/09/2026 at 1:25 P.M., Social Worker #14 stated the advanced directive care plans for Resident #7 and Resident #101 included interventions implemented by the previous Social Worker. They stated that the interventions had remained unchanged, even though they should have been updated. They stated that Social Services should have revised the interventions to accurately reflect the residents' code status as Full Code (cardiopulmonary resuscitation) During an interview on 04/10/2026 at 12:30 P.M., the Director of Social Services stated that when a resident had a Full Code status, interventions were to be put in place to reflect the code status. They stated that there should not have been any interventions for a do not resuscitate when residents were designated as Full Code status. 10 New York Code Rules Regulations 415.11(c)(2) (i-iii)		

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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequency of toileting provided. During an interview on 04/10/2026 at 9:40 A.M., the Registered Nurse Supervisor # 3 stated although Resident #145 could be transferred with two-person assistance to the bathroom or commode posed safety and privacy concerns due to the tight space in the bathroom, which requires both doors to remain open during transfers and toileting. Registered Nurse Supervisor #3 stated that the most appropriate and safe intervention for the resident was to provide frequent toileting in bed at a minimum of every two (2) hours. Registered Nurse Supervisor #3 stated they were not aware of how often staff were actually checking or toileting the resident. 10 New York Code Rules Regulations 415.12 (a)(3)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review the facility failed to ensure that care and services were provided in accordance with resident preference and professional standards of practice that met physical and psychosocial needs for one (1) of one (1) resident (Resident #74) reviewed for rehabilitation and restorative. Specifically, a prosthetic fitting was not completed as per the 08/06/2025 vascular consultation recommendation for Resident #74 with a left below knee amputation. The findings included: Resident #74 was admitted to the facility with diagnoses including status post below knee amputation from diabetic ulcer and gangrene, diabetes mellitus and legally blind. The Vascular Consultation report dated 08/06/2025 documented left below knee amputation is healed, ready for prosthesis fitting. The facility's attending physician signed the consultation report. The Nursing Progress note dated 08/06/2025 documented the resident returned to the unit in a wheelchair with the following recommendation, left below knee amputation is healed and ready for prosthesis fitting. Physician notified. The Physician Order dated 08/06/2025 documented physical therapy screen, evaluation, and treatment. There was no documented evidence of a physician order to address the prosthetic fitting as per vascular consultation recommendation. The Care Plan for rehabilitation initiated 03/11/2026 documented activity of daily living rehabilitation program for decreased endurance, decreased performance in activities of daily living, bed mobility, transfers, generalized weakness, and impaired balance with a goal to maintain current level of function and an intervention to praise all efforts at self-care. The quarterly Minimum Data Set (resident assessment tool) dated 03/23/2026 documented Resident #74 had moderate cognitive impairment. During an observation and interview on 04/08/2026 at 9:27 AM, Resident #74 was sitting on the side of the bed. Resident #74 stated the facility refused to get a prosthesis for their left below knee amputation. They stated they were told their insurance did not allow for a prosthesis. They stated they wanted to learn how to use a prosthesis to be able to be discharged. During an interview on 04/13/2026 at 11:08 AM, the Director of Rehabilitation stated Resident #74 received therapy upon admission and was discharged from therapy 10/2025 when they reached maximum potential. The Director of Rehabilitation stated that due to Resident #74's impaired vision they felt it would not be safe for Resident #74 to have a prosthetic leg. During an interview on 04/14/2026 at 9:18 AM, Licensed Practical Nurse #23 stated they recalled a vendor from the rehabilitation department visiting Resident #74 to evaluate for a prosthesis but were not sure of the outcome. Licensed Practical Nurse #23 stated they did not see any reason why Resident #74 should not have a prosthetic leg. During an interview on 04/14/2026 at 10:16 AM, the Director of Rehabilitation stated Resident #74 was seen on 06/26/2025 but the resident's insurance was out of network and did not qualify for a prosthetic leg. The Director of Rehabilitation stated it was an oversight that a referral was not made to another vendor to evaluate Resident #74 for a prosthesis. During an interview on 04/14/2026 at 2:36 PM the Medical Director/Primary Physician stated they observed Resident #74 perform a transfer from the wheelchair to the bed and stated Resident #74 should have a prosthesis. 10 New York Code Rules Regulations 415.12		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to ensure residents who needed respiratory care were provided such care consistent with professional standards of practice for one (1) of three (3) residents reviewed for respiratory care. Specifically, Resident #85 had a physician order for oxygen to be delivered at two to three liters per minute via nasal cannula and was administered 4.5 liters of oxygen. The findings included: The Policy for oxygen administration last updated 05/2025 documented adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Resident #85 was admitted with diagnoses including end stage renal disease, chronic obstructive pulmonary disease and hypertension. The Physician Order dated 01/26/2026 documented oxygen two to three liters per minute via nasal cannula every shift for chronic obstructive pulmonary disease. The 02/02/2026 admission Minimum Data Set (assessment tool) documented Resident #85 had intact cognition and received oxygen therapy. The Care Plan for oxygen therapy dated 02/04/2026 documented give oxygen as ordered. During observations on 04/08/2026 at 11:30 AM and 04/09/2026 at 3:52 PM, Resident #85 was receiving 4.5 liters of oxygen via nasal cannula. During an interview on 4/09/2026 at 3:56 PM, Registered Nurse #17 stated Resident #85 was receiving 4.5 liters of oxygen. They stated Resident #85 should receive 2 to 3 liters of oxygen per minute as per physician order. They stated nurses were responsible for checking the flow rate on the oxygen concentrator. During an interview on 4/09/2026 at 4:02 PM, Registered Nurse Unit Manager #16 stated they did not know why Resident #85's oxygen flow rate was set and administered so high. They stated the nurses were responsible for administering the oxygen as per the doctor's order. 10 New York Code Rules Regulations 415.12 (a) (3)		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on record review, observation and interview the facility failed to ensure that residents were seen by a Physician at least once every thirty days for the first ninety days after being admitted to the facility for one (1) of five (5) residents (Resident #14) reviewed for infection control. Specifically, there was no documented evidence that Resident #14 who was admitted to the facility 01/2026 was seen by a medical provider after 02/14/2026. The findings included: The undated facility policy titled Physician Services documented the attending physician will perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage. Review of orders are provided during monthly physician visits and documentation in physician's notes. Resident #14 was admitted with diagnoses including osteomyelitis of vertebra sacral and sacrococcygeal region, arthritis due to other bacteria, right knee, tropical spastic paraplegia and methicillin resistant staphylococcus aureus infection, unspecified site. The admission Minimum Data Set (a resident assessment tool) dated 01/20/2026 documented Resident #14 had moderate cognitive impairment, one (1) stage three (3) and one (1) stage 4 (four) pressure ulcer and two (2) venous/arterial ulcers present upon admission. The electronic medical record documented Resident #14 was assessed by the facility physician on 01/20/2026, 01/21/2026, 01/26/2026, 02/04/2026 and 02/14/2026. There was no documented evidence that Resident #14 was assessed after 02/14/2026 by facility physician. The Nurse Practitioner note dated 01/20/2026 documented Resident #14 had a face-to-face visit. The Nurse Practitioner note dated 01/21/2026 documented Resident #14 received an on-call telemedicine visit and a face-to-face physician visit. The Physician note dated 01/26/2026 documented Resident #14 had a face-to face visit with the facility physician. The Physician note dated 02/04/2026 documented Resident #14 had a face-face visit with facility physician for a blister and rash concern. The Physician noted dated 02/14/2025 documented Resident #14 received a face-to-face follow-up visit by the facility physician. There was no documented evidence that Resident #14 was assessed by the facility physician after 02/14/2026. During an interview and observation on 04/09/2026 at 5:24 PM the Director of Nursing stated they were unaware as to why Resident #14 had not been assessed by the facility primary care physician since 02/14/2026 and not assessed at least monthly since admission as per facility policy and regulations. During an interview on 04/10/2026 at 3:09 PM, Unit Manager Registered Nurse #3 stated newly admitted residents should have a physician visit after admission, monthly thereafter and as needed for acute developments. They stated physicians could run a report to view residents who were due for an assessment. During an interview on 04/13/2026 at 5:37 PM Primary Physician #2 stated Resident #14 was assessed upon admission and again in 02/2026. They stated new admission residents, including Resident #14, should be assessed monthly for the first 90 days. They stated they were aware there was no documented evidence of an assessment in 03/2026 for Resident #14. 10 New York Codes Rules Regulations 415.15(b)(2)(ii)		

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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. Based on observation, record review, and interview the facility failed to ensure that all drugs and biologicals were stored in accordance with the manufacturer's specifications and professional standard of practice for one (1) of one (1) resident (Resident #116) reviewed for medication storage. Specifically, Resident #116 room was observed to have physician ordered medications / treatments on the bedside table that included two (2) opened packets of maximum strength lidocaine pain relief gel patch 4%, each pouch contained one (1) patch. The findings included: A policy titled Medication Administration, revised 11/2025, documented nursing personnel shall ensure the safe and effective administration of medications. Medication should not be left at the bedside for the resident to take later. Resident #116 diagnoses included low back pain, type two (2) diabetes mellitus without complications, and pain in the left knee. The quarterly Minimum Data Set (a resident assessment tool) dated 03/29/2026 documented Resident #116 was cognitively intact. The Physician order dated 06/19/2025 documented lidocaine external gel 4 % (lidocaine) apply to left thigh topically in the morning for thigh pain. The Physician order dated 06/19/2025 documented lidocaine external patch 4 % (lidocaine), apply to left shoulder topically one time a day for pain. Remove after 12 hours. There was no documented evidence that Resident #116 was assessed, and care planned for medication self-administration. During an observation and interview on 04/08/2026 at 9:40 AM two (2) opened pouches of maximum strength lidocaine pain relief gel patch 4%, one patch per pouch were present on Resident #116's bedside table. Resident #116 stated Unit Manager Registered Nurse #3 left the lidocaine patches earlier in morning and they independently applied patches after they showered/bathed. They stated Unit Manager Registered Nurse #3 frequently left the lidocaine patches for self-administration. During an observation and interview on 04/08/2026 at 9:54 AM, Unit Manager Registered Nurse #3 stated they presented to Resident #116's room earlier with lidocaine patches and that Resident #116 stated they were washing up and not ready for the patches. They stated they left the lidocaine patches at the bedside because they were distracted by another resident. They stated they usually informed Resident #116 to let them know when they were ready for lidocaine patches to be placed and would then return to place the patches. During an interview on 04/14/2026 12:22 PM, the Director of Nursing stated medications, including lidocaine patches, should not be left at bedside/in room for resident self-administer unless the resident was care planned and assessed in safe medication administration. 10 New York Code Rules Regulations 415.18(e)(1-4)		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, record review and interview the facility failed to ensure proper disposal of garbage and refuse. Specifically, 1) the recycling dumpster lid was left open and there were cardboard boxes spilling over the top and other debris was observed behind and to the side of the dumpster, and 2) the garbage compactor had food debris puddled in front of the compactor door and litter on the ground surrounding the compactor. Findings Include: A review of the policy and procedure titled Garbage Removal Policy reviewed 09/2025 documented, the facility shall ensure safe, sanitary, and compliant management of all waste in accordance with federal, state, and local regulations to maintain a clean and safe environment. Waste shall be stored in designated areas and must be clean and well-maintained, pest-resistant and not accumulated beyond acceptable limits. During an observation of the garbage area and interview on 04/07/2026 at 10:43 AM the recycling dumpster was open with cardboard boxes spilling over the top. There were boxes and other debris behind and to the side of the dumpster. The garbage compactor had food debris that had spilled down the front of the compactor door and was puddled at the base of the compactor. There were used gloves, plastic utensils, and an empty ice cream cup on the ground surrounding the compactor. There was a bag of garbage sitting on the top of the compactor. The Food Service Director stated the lid on the recycling dumpster should be closed. The garbage was used by the whole facility; everyone was responsible for keeping the area clean. During an interview on 04/13/2026 at 11:29 AM, the Housekeeping Supervisor stated the dumpster lid should be closed. They stated they checked every morning when they arrived to make sure the dumpster lid was closed, and they were not sure why the dumpster lid was open on 04/07/2026. They stated all staff were educated about closing the lid and cleaning the area when waste was not in the dumpster or compactor. They stated the garbage pick-up schedule was once or twice a week, but three (3) weeks ago they requested a more frequent pick up to prevent waste overflow. During an observation on 04/14/2026 at 10:28 AM the recycling dumpster lid was open with boxes spilling over the top. 10 New York Code Rules Regulations 415.14(h)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Hudson Hill Center for Rehabilitation & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection for two (2) of five (5) residents (Resident #14 and Resident #56) reviewed for infection control. 1) Specifically, Physical Therapist Assistant #15 provided range of motion without the use of a gown for Resident #14 with a physician order for contact precautions. Additionally, the precaution sign on Resident #14's door indicated enhanced barrier precautions and 2) Certified Nurse Aide #7 provided cares without the use of a gown for Resident #56 with an indwelling supra-pubic catheter who had a physician order for enhanced barrier precautions. The findings included: The policy titled Infection Prevention and Control Program, revised 01/2025, documented that the infection prevention and control program was a facility-wide effort involving all disciplines and individuals and was an integral part of the quality assurance and performance improvement program. It included educating staff and ensuring that they adhered to proper techniques and procedures. The policy titled Enhanced Barrier Policy, revised 01/2026, documented Enhanced Barrier Precautions was to prevent opportunities for transfer of multidrug-resistant organisms to employees' hands and clothing during care, beyond situations in which staff anticipated exposure to blood or body fluids. In high-contact resident care activities such as dressing, bathing/showering, transferring, and providing hygiene, staff were required to wear gloves and gowns. 1) Resident #14 was admitted with diagnoses including osteomyelitis of the vertebra sacral and sacrococcygeal region, tropical spastic paraplegia and methicillin resistant staphylococcus aureus infection. The admission Minimum Data Set (a resident assessment tool) dated 01/20/2026 documented Resident #14 had moderate cognitive impairment, was incontinent of bowel and bladder, and had one (1) stage three (3) and one (1) stage 4 (four) pressure ulcer and two (2) venous/arterial ulcers present upon admission. The Physician Order dated 01/20/2026 documented contact precautions due to methicillin resistant staphylococcus aureus infection in synovial fluid. The Care Plan for contact precautions due to methicillin resistant staphylococcus aureus infection in synovial fluid dated 01/25/2026 obtain physician order for precautions. Place precaution alert signs on resident's door. Wear gown and gloves when providing care. During an observation on 04/08/2026 at 1:04 P.M., Resident #14's room had an enhanced barrier precaution sign at the doorway. During an observation and interview on 04/09/2026 at 3:39 P.M., Physical Therapy Assistant #15 provided bilateral leg passive range of motion with the use of gloves and a mask and did not wear a gown. Physical Therapy Assistant #15 stated they forgot to wear a gown. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/2026 at 5:00 P.M., Registered Nurse #19 stated Resident #14 had an active physician order and resident care plan for contact precautions. They stated the sign on Resident #14's door indicated the resident was on enhanced barrier precautions. Registered Nurse #19 stated they provided medication and wound care for Resident #14 and followed enhanced barrier precautions. During interview on 04/09/2026 at 5:24 P.M., and 04/10/2026 at 12:33 P.M., the Director of Nursing stated Resident #14 was on enhanced barrier precautions as per the sign at the door for wounds and was not on contact precautions. The Director of Nursing stated there was an active physician order and resident care plan for contact precautions and were unsure exactly when contact precautions ended. They stated Resident #14 would have been removed from contact precaution when their white blood count returned to within normal limits. After reviewing the electronic medical record, they stated Resident #14's white blood count was 8.83 on 01/22/2026 and increased to 10.99 on 03/20/2026. The Director of Nursing stated they were unsure if Resident #14 would have been removed from contact precautions with the increase in white blood count. 2. Resident # 56 had diagnoses including neurogenic bladder, Parkinson's disease, and bipolar disorder. The Care Plan initiated 07/17/2024 documented enhanced barrier precautions to reduce the risk of infection, use personal protective equipment, and ensure proper signage was posted on the resident's door. The Physician Order dated 07/17/2024 documented enhanced barrier precaution every shift for infection prevention. The quarterly Minimum Data Set, dated [DATE] documented Resident #56 had severe cognitive impairment and had an indwelling supra-pubic catheter in place. During an observation/interview on 04/07/2026 at 4:45 P.M., Certified Nurse Aide #7 changed Resident #56's brief and emptied and closed the indwelling catheter leg bag without the use of a gown. There was no enhanced barrier precautions sign in place and no personal protective equipment cart outside Resident #56's room. Certified Nurse Aide #7 stated they did not have to wear a gown because the resident was not on contact precautions. During an interview on 04/07/2026 at 5:18 P.M., Registered Nurse Unit Manager #6 stated the enhanced barrier precautions sign on the door to Resident #56's room was probably removed by a resident. They stated they educated the Certified Nurse Aides regarding the enhanced barrier precaution sign but had no documentation of the education. During an interview on 04/14/2026 at 10:46 A.M., the Nurse Educator stated all Certified Nurse Aides were in-serviced on infection control and prevention, including enhanced barrier precautions. They stated Certified Nurse Aide #7 was in-serviced on enhanced barrier precautions. They stated they observed staff as they performed their tasks for enhanced barrier precautions, to ensure they followed proper infection control protocols. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation showed that Certified Nurse Aide #7 received in-service training on enhanced barrier precautions dated 06/18/2025. 10 New York Code Rules Regulations 415.19(a) (1-3)		