

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Hudson Pointe at Riverdale Ctr for Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3220 Henry Hudson Parkway Bronx, NY 10463	

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 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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and staff interview, conducted during the abbreviated survey (#2651294) the facility did not ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the New York State Department of Health. This was evident for one (1) of four (4) residents (Resident #1) sampled. Specifically, on 10/12/2025 Resident #1 had an unwitnessed fall out of bed and sustained discoloration of the left eye which the facility did not report. The findings are: The facility policy titled 'Abuse' last reviewed on 03/11/2024 documented it is the policy of facility that each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion and misappropriation of funds. The policy also documented federal and state regulations require the reporting of alleged violations of abuse, mistreatment and neglect, including injuries of unknown origin, immediately to the facility administrator. The policy further stated federal regulations require that the facility must ensure all alleged violations involving mistreatment, neglect and abuse are reported immediately to the administrator of the facility and to other officials in accordance with State law. Resident # 1 was admitted to the facility with diagnoses that included Coronary Artery Disease, Diabetes Mellitus, and Non-Alzheimer's Dementia. A review of the Minimum Data Set (a resident assessment tool) dated 08/31/2025 documented Resident #1 was moderately cognitively impaired, they were dependent on staff for most activities of daily living, including transfer, and they used a wheelchair for mobility. The Physician's progress note dated 10/12/2025 documented Resident #1 had an unwitnessed fall early this morning sustaining injury to left eye. From staff, mentation is the same, Ice pack has been applied, Patient is able to open their eye, neuro check every 8 hours. Ice compress to left eye hematoma. Tylenol for pains as needed. Transfer to hospital emergency room for evaluation. The nursing progress note dated 10/12/2025 at 5:03 AM documented they were called to assess Resident #1 who was noted on the floor next to their bed which is at its lowest position. Swelling noted around left eye. Resident #1 was unable to explain incident. Nursing Supervisor was informed, Physician was informed, ice pack applied. Resident was transferred to the hospital for further evaluation. The Accident/Incident report summary dated 10/12/2025 documented Resident #1 was alert but confused, required extensive assistance with activities of daily living including transfer, and was observed on the floor near their bed. Resident #1 was unable to provide an account of what happened. Resident #1 was noted with hematoma of left eye, no loss of consciousness, no change in mental status. On 10/27/2025 at 1:20 PM, the Director of Nursing was interviewed and stated Resident #1 was found on the floor with an injury to the left eye and was sent to the hospital. The Director of Nursing also stated it was an unwitnessed fall, and there was no abuse involved. The Director of Nursing further stated Resident #1 was last seen by staff between 4:30 AM and 4:45 AM, and the incident was not reported to the Department of Health, because Resident #1 was sent to the hospital for treatment and the facility did what it needed to do. On 10/27/2025 at 2:00 PM, the Administrator was interviewed and stated the Director of Nursing did not report the incident to the Department of Health because there was no suspicion of any abuse, and Resident #1 was sent to the hospital. 10 NYCRR 415.4(b)(2)</p>		