STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335187	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Pointe at Riverdale Ctr for Nursing & Rehab	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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136 Based on observations, record review, and interviews conducted during the Recertification survey from 07/21/2024 to 07/26/2024, the facility did not ensure that it promoted and facilitated resident self-determination by supporting resident choice. Specifically, residents' bathing preferences were not honored. This was evident for 2 of the 4 residents reviewed for Choices out of 38 sampled residents. (Resident #88, and #46). The findings are: The facility policy and procedures titled ADL-Shower with the last revised date February 2024 documented that it is the policy of the facility to shower residents, to cleanse, and refresh resident, observe the skin and to provide increased circulation. Place resident in a shower chair and drape with a bath blanket or other form of cover. 1. Resident #88 was admitted to the facility with diagnoses that included Peripheral Vascular Diseases and Depression. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #88 as cognitively intact and dependent on staff for Activities of Daily Living (ADLs). No rejection of care was documented. The Annual Minimum Data Set assessment dated [DATE] documented that it is very important for Resident #88 to choose between a tub bath, shower, or sponge bath. On 07/22/2024 at 9:58 AM, Resident # 88 was observed out of bed in a Geri chair in their room. The resident was interviewed and stated that I would like to get a shower, but I have not had a shower since I came to the facility. They wipe me down. The Resident Nursing Instructions dated 05/19/2023 documented that Resident #88 is scheduled for bathing on Mondays and Thursdays during the 3:00 PM to 11:00 PM shift. Bathing types documented include bed bath, shower, and sponge bath. The instructions did not specify Resident #88's preference. The Resident CNA Documentation History Detail Report dated 01/01/2024 to 07/22/2024 documented tasks performed bathing type bed bath. There was no documented evidence that a shower was provided. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes dated 07/01/2024 to 07/24/2024 contained no documented evidence that Resident #88 had been offered and/or refused showers. On 07/24/2024 at 11:19 AM, Certified Nursing Assistant #1 was interviewed and stated that Resident #88 gets showers during the evening shift. Certified Nursing Assistant #1 does not know if the resident gets the shower. On 07/24/2024 at 3:23 PM, Certified Nursing Assistant #2 was interviewed and stated that Resident # 88 gets showers on Mondays and Thursdays during the evening shift. The resident is taken out of bed and taken to the shower room for the shower. At times, the resident will say they do not want to go to the shower room because they have pains. Resident #88 cannot sit in the shower chair, so I gave the resident a shower in the Geri chair, but I documented it as a bed bath. The administration is unaware that the resident cannot sit in the shower chair. I gave the resident a bed bath on Monday. I documented it in the kiosk and clicked bed bath. On 07/24/2024 at 3:36 PM, Certified Nursing Assistant #3 was interviewed and stated that they worked the evening shift and had not seen Resident #88 getting a shower before. They document the shower in the kiosk. If the resident receives a shower, I will click shower, I click bed bath when a resident gets a bed bath. On 07/25/2024 at 11:47 AM, the Unit Manager was interviewed and stated that the Certified Nursing Assistant documents care provided in the kiosk. The assigned charge nurse and the supervisors monitor and ensure care is provided. The Licensed Practical Nurse on the day and the evening shift ensures that residents are getting showers on each shift. There has not been any report that the staff needs a special shower chair to give Resident #88 a shower. We do not use Geri-chairs for showers. On 07/25/2024 at 12:10 PM, the Director of Nursing was interviewed and stated that they offer residents shower two times a week, as needed, as requested, and per the resident's preference. Resident #88's accountability record shows the task was performed, and the bathing type was documented as a bed bath. This is the first time I have heard that Resident #88 does not get a shower. I have not heard that the resident cannot sit in the shower chair. If a problem arises, we will refer the resident to rehab and provide the proper care and equipment. If Resident #88 cannot sit in the shower chair, the resident will need a a special shower chair. The resident can use a reclining shower chair in one of the units. If a resident refuses to shower, it should be documented in the accountability record. We do not use Geri-chair for showers. 48876 2) Resident #46 was admitted to the facility with diagnoses that included Coronary Artery Disease and Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], identified Resident #46 as cognitively intact, dependent on staff for all surface transfers and requiring moderate assistance with showers and bathing. On 07/25/24 at 12:18 PM, Resident #46 was observed in bed. An interview was conducted when Resident #46 stated that they are not offered showers and that the Certified Nursing Assistant just gives me a bed bath. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan Activity Report last updated 04/01/2024, documented that Resident #46 is scheduled to be showered on Tuesdays and Saturdays during the 7:00 AM to 3:00 PM shift. Bathing type documented is shower with instructions to inform the nurse if the resident is refusing showers. There is no documented evidence that Resident #46 was refusing showers. The Resident CNA Documentation History Detail Report dated 06/01/2024 to 07/23/2024 documented task performed - bathing, type - bed bath. There was no documented evidence that Resident #46 was offered or received a shower. The Resident Certified Nursing Assistant Documentation History Detail Report, dated 06/01/2024 to 07/23/2024, documented that Resident #46 did not resist care. There was no documented evidence that Resident #46 refused showers. On 07/25/24 at 09:28 AM, an interview was conducted with Certified Nursing Assistant #6 who stated that every resident should be offered a shower twice a week and bed baths should be performed on the other days, resident #46 is scheduled to be showered on Tuesdays and Saturdays but usually gets a bed bath. Certified Nursing Assistant #6 also stated that all the Certified Nursing Assistants document daily in the computer system whether a shower or bath is given. Certified Nursing Assistant #6 further stated that if a resident refuses care, the nurse should be notified. On 07/25/2024, Registered Nurse #3, the floor supervisor, was interviewed and stated that Resident #46 should have been provided all the Activity of Daily Living Care which included a shower twice a week, and if the resident refused it should have been reported by the Certified Nursing assistant and documented by the charge nurse. Registered Nurse #3 further stated that they were unable to locate any documentation that Resident #46 was offered or refused showers. On 07/25/2024, The Director of Nursing was interviewed and stated that they were informed by Registered Nurse #3 that there was no documentation that Resident #46 refused to be showered. The Director of Nursing then confirmed that there was also no documentation found that Resident #46 had been offered or refused showers. 415.5(b) (1-3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observations, record reviews and interviews conducted during the Recertification survey, the facility did not ensure that Minimum Data Set (MDS) 3.0 assessments accurately reflected the residents' status. Specifically, the most recent Minimum Data Set (MDS) 3.0 assessments did not reflect that wander/elopement alarms were used for 2 residents. This was evident for 2 of 2 residents reviewed for Elopement Risk out of a sample of 38 residents. (Resident # 103 and #135). The findings are: 1.) Resident #103 was admitted to the facility with diagnoses which include Dementia, Depression, and Psychotic Disorder. The quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] documented the resident had impaired cognition and was dependent in performing activities of daily living. Also documented in the Section P0200-Alarm that Wander/Elopement Alarm was not used. On 07/22/24 at 12:15 PM Resident #103 was observed with a wander guard device on the right wrist. Elopement Risk assessment dated [DATE] documented that if the resident scored 3 or more negative responses, notify MD, initiate use of Wander guard and follow facility protocol/guidelines, create/update Care plan for Elopement, Update CNA Instructions. The Physician Order's dated 12/07/2022, last revised on 07/17/24 documented the following: Wander Guard-Check Q Shift for Placement. The Comprehensive Care Plan for Behavior Symptoms: Wandering/Elopement risk dated 3/18/24, revised 6/27/24 documented interventions which included: check ID bracelet is on wrist, WG to Right Wrist, and maintain safety. The Medication Administration Record (MAR) dated 07/1/24 to 07/22/24 documented the observation of the wander guard device every shift daily (7:00 AM, 3:00 PM, and 11:00 PM). 2.) Resident #135 was admitted to the facility with diagnoses which include Dementia, Anxiety and Depression. The Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] documented the resident had impaired cognition and was dependent in performing activities of daily living. Also documented in the Section P0200-Alarm that Wander/Elopement Alarm was not used. Elopement Risk assessment dated [DATE] documented that the resident scored 3 or more negative response notify MD, initiate use of Wander guard and follow facility protocol/guidelines, create/update Care plan for Elopement, Update CNA Instructions. The Medication Administration Record (MAR) dated 07/1/24 to 07/22/24 documented the observation of the wander guard device every shift daily (7:00 AM, 3:00 PM, and 11:00 PM). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan for Behavior Symptoms: Wandering/Elopement risk dated 02/26/24 revised 06/21/24 documented interventions which included check ID bracelet is on wrist, WG to Right Wrist, and maintain safety. The Physician Order's dated 12/07/2022, last revised on 07/17/24 documented the following: Wander Guard-Check Q Shift for Placement. On 07/23/24 at 10:52 AM , an interview was conducted with the MDS Supervisor who stated that the MDS assessor performs physical assessment and review records and intervening staff when completing MDS assessments. They also stated that they should not solely rely on medical records, and they have to see the residents. The MDS supervisor stated that they have just completed a review of all residents on wander guards and they discovered that these 2 residents were not coded accurately. They concluded by saying It could have been an oversight for these 2 residents captured. 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** 43350 Based on interviews, observations and record review conducted during a recertification survey (EUC311), the facility did not ensure that a resident's care plan for falls was reviewed and revised. Specifically, staff did not complete a timely review and/or revision for the care plan for a resident who had an identified history of falls with injury. This was evident in 1 of 31 residents reviewed for care plans (Resident #52). The findings are: The facility's policy and procedure entitled Care Plan, Comprehensive, last updated 02/2024, states that the interdisciplinary team reviews and updates the care plans at least quarterly in conjunction with the required Minimum Data Set assessment. Resident #52 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Depression, Chronic Kidney Disease and Diabetes. The Minimum Data Set (a resident assessment tool) dated 06/03/2024 documented that the resident's cognition was severely impaired, that they wandered daily and used a Wanderguard to prevent their accessing the unit stairwells and elevators. A Falls Potential Care Plan was initiated for the resident on 01/09/2020 with interventions to check the equipment for the resident's use daily for stability, encourage the resident to ask for assistance when needed, anticipate needs, keep the call bell within reach and answer promptly, keep the resident's items within easy reach, review their medications, provide a well-lit and hazard free environment, redirect their behavior, refer to PT/OT for evaluation, provide a low bed with no side rails and toilet the resident as scheduled. A Nursing note dated 11/28/2023 at 11:27 AM stated that at 8:30 AM, staff responded to a sound in the resident's room and found Resident #52 sitting on the floor at the foot side of their bed. The resident was awake, alert and responsive but was unable to state what had happened and was attempting to get up by themselves. The resident was assisted back to bed and was seen by the Nurse Practitioner, who noted a small raised area on their forehead with slight redness but no bleeding and ordered a skull x-ray, which was negative. The Nurse Practitioner also ordered a Physical Therapy evaluation, and the resident's next of kin was made aware. The Falls Care Plan was reviewed and updated with a note reflecting the fall. Resident #52's Minimum Data Sets were reviewed and noted that the resident had two quarterly assessments so far in 2024, in March and in June, but their Falls Care Plan had no reviews noted at any point in 2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/26/2024, Registered Nurse #4 was interviewed and stated that at the time of their fall, Resident #52 was able to ambulate independently but was confused. After their fall, more frequent rounding on all rooms was made. The Nurse Manager stated that they are responsible for reviewing and updating care plans with issues that take place during the day shift; they updated the Falls Care Plan in December 2023 as well as all the resident's other care plans. The Nurse Manager was unable to explain why the Falls Care Plan was not updated in 2024. On 07/26/2024 at 10:53 AM, Registered Nurse #1 was interviewed and stated that they were the Nurse Supervisor covering Resident #52's unit at the time of their fall. However, the Nurse Manager was the person responsible for updating all care plans, and although they were supervising the Nurse Manager on 11/28/2023, they were covering the resident's unit only. The Nurse Supervisor stated that Resident #52 was recently hospitalized and returned to the second floor. On 07/26/2024 at 12:07 PM, Licensed Practical Nurse #1 on the second floor was interviewed and stated that Resident #52 had been on this unit for about ten days and had had no falls during that time. However, the resident is currently not ambulatory. The nurse stated that the resident now spends their day in rehab or in the unit day room, where they participate in activities and have constant staff supervision. The nurse stated that the resident will have their readmission assessment in a few days and their care plans will be updated, including the Falls Care Plan. 483.21(b)(2)(i-iii)