

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
NAME OF PROVIDER OR SUPPLIER Sans Souci Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Park Avenue Yonkers, NY 10703	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on video surveillance, record review, and interviews conducted during the Abbreviated Survey (2595161), the facility did not ensure that residents were free from abuse, neglect, and mistreatment for 1(Resident #1) of 3 residents reviewed for abuse. Specifically, on 08/19/2025 at 11:55 PM, video surveillance reviewed revealed interaction between resident #1 and Licensed Practical Nurse #1. Resident #1 was seated in their wheelchair in the doorway of their room while Licensed Practical Nurse #1 was at the medication cart with their back turned to Resident #1. Licensed Practical Nurse #1 is seen turning around and began a verbal exchange with Resident #1. Licensed Practical Nurse #1 is seen moving behind Resident #1's wheelchair and attempt to hold Resident #1's hand down and force him back into their room. Resident #1 is seen resisting. Licensed Practical Nurse #1 continued attempting to pull Resident #1 while seating in their wheelchair into their room. The Findings Include: Resident #1 was admitted with diagnosis including but not limited to aphasia, cerebral infarction, and hemiplegia and status post revision of right total knee arthroplasty due to chronic loosening of joint. The 7/20/25 Discharge Minimum Data Set indicated that Resident #1 had moderately impaired cognition was independent with eating and bed mobility, required supervision and set up assistance with transfers and toileting, and was independent with wheelchair mobility. Video Surveillance footage with no audio dated 08/19/2025, timestamped at 11:55 PM, was reviewed by surveyors in the presence of the Director of Human Resources and the Director of Nursing on 08/25/2025 at 1:26 PM. The footage showed Resident #1 seated in their wheelchair in the doorway of their room while Licensed Practical Nurse #1 stood at the medication cart with their back turned to Resident #1. Licensed Practical Nurse #1 turned around and engaged in a verbal interaction with Resident #1. Resident #1 was observed moving closer to Licensed Practical Nurse #1, both using hand gestures during the exchange. Resident #1 stood up from their wheelchair and sat back down. Shortly after Licensed Practical Nurse #1 was seen moving behind Resident #1's wheelchair and attempted to hold Resident #1's hand down and force him back into their room. Resident #1 was seen resisting and holding on to the frame of the doorway, however, Licensed Practical Nurse #1 continued to attempt to forcefully pull the resident, while the resident was seated in the wheelchair, into the room by holding onto the resident's hands and shoulders, despite the resident resisting. The Investigation Summary dated 08/20/25 documented that at approximately 12:30 AM, a reported interaction in which Licensed Practical Nurse #1 was observed by Certified Nurse Aide #1 speaking loudly to Resident #1 and allegedly pulling the resident by the shoulders while maneuvering their wheelchair backwards. Resident #1, experiencing pain, requested their scheduled pain medication from Licensed Practical Nurse #1 while they were administering medications to other residents. Licensed Practical Nurse #1 instructed Resident #1 to wait in their room until they complete their medication pass. Resident #1 became upset and positioned themselves in their wheelchair at the doorway of their room approaching Licensed Practical Nurse #1. Licensed Practical Nurse #1 reported that they stepped away for safety, moved behind the resident's wheelchair, and attempted to assist Resident #1 back into a seated position while reversing the wheelchair toward their room to clear the path for their medication cart. Licensed Practical Nurse #2 arrived in the hallway near room [ROOM NUMBER] and observed Licensed Practical Nurse #1 attempting to maneuver Resident #1's wheelchair to bypass with the medication cart. Licensed Practical Nurse #2 intervened, wheeled Resident #1 to the side, to allow Licensed Practical Nurse #1 to proceed. During an interview on 8/25/25 at 11:44 am, Resident #1 stated that they were sitting in their doorway in a wheelchair and requested their pain medication from the nurse. The resident stated that the nurse appeared very upset and refused to provide the medication. Resident #1 further stated that the nurse then began pulling their wheelchair backward, while holding their arms attempting to force them out of the hallway. During an interview on 8/25/25 at 11:46 AM, a family member of Resident #1, they reported that Resident #1 informed them they had requested pain medication but did not receive it promptly. The family member stated that the nurse refused to provide the residents' pain medications and put their hands on Resident #1 without their permission. During an interview on 08/25/2025 at 12:35 PM, Certified Nurse Aide #1, they stated that they heard yelling in the hallway and identified raised voices from both Licensed Practical Nurse #1 and Resident #1. They heard Licensed Practical Nurse #1 instruct Resident #1 to return to their room and told them that they could not administer the pain medication, and that the night nurse would provide them with their medication. Certified Nurse Aide #1 further stated that they observed Licensed Practical Nurse #1 wheel Resident #1 backwards into their</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the Abbreviated Survey (2595161), the facility did not ensure that all alleged violations involving abuse, neglect, or mistreatment were thoroughly investigated for 1 of 3 residents reviewed (Resident #1). Specifically, on 08/19/2025 at 11:55 PM, video surveillance footage revealed Licensed Practical Nurse #1 engaged in a verbal interaction with Resident #1. Resident #1 and Licensed Practical Nurse #1 were using hand gestures during the interaction. Licensed Practical Nurse #1 moved behind the wheelchair and attempted to pull the resident back into their room. Resident #1 was seen resisting and Licensed Practical Nurse #1 continued to forcefully pull the resident while seated in the wheelchair, into their room. Licensed Practical Nurse #1 was seen holding the resident's arms and shoulders at a point despite the resident resisting. The facility's internal investigation ruled out abuse, neglect, or mistreatment. The facility submitted an internal investigation to the New York State Department of Health that ruled out abuse, neglect, or mistreatment. However, the facility internal investigation report did not include a review of video surveillance footage and no documented evidence that an interview was conducted with Resident #1's roommate, who was present in the room at the time of the incident. The Findings Include: The facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating revised 05/01/2025 documented that all investigations are thoroughly investigated, reviews all events leading up to the alleged incident, and documents the investigation completely and thoroughly. Resident #1 was admitted with diagnosis including but not limited to aphasia, cerebral infarction, and hemiplegia and status post revision of right total knee arthroplasty (a procedure that replaces damaged parts of the knee with artificial components made of metal or plastic). The 7/20/25 Discharge Minimum Data Set indicated that Resident #1 was independent with eating and bed mobility, required supervision and set up assistance with transfers and toileting, and was independent with wheelchair mobility. Resident #1 had moderately impaired cognition. The 8/20/25 Investigation Summary documented that at approximately 12:30 AM, an allegation arose from a reported interaction in which Licensed Practical Nurse #1 was observed by Certified Nurse Aide #1 speaking loudly to Resident #1 and allegedly pulling the resident by the shoulders while maneuvering their wheelchair backwards. Resident #1, experiencing pain, requests their scheduled pain medication from Licensed Practical Nurse #1 while they are administering medications to other residents. Licensed Practical Nurse #1 instructs Resident #1 to wait in their room until they complete their medication pass. Resident #1 becomes upset and positions themselves in their wheelchair at the doorway, approaching Licensed Practical Nurse #1. Licensed Practical Nurse #1 later reports that they stepped away for safety, moved behind the wheelchair, and attempted to assist Resident #1 back into a seated position while reversing the wheelchair toward their room to clear the path for their medication cart. Licensed Practical Nurse #2 arrives in the hallway near room [ROOM NUMBER] and observes Licensed Practical Nurse #1 attempting to maneuver Resident #1's wheelchair aside to pass with the medication cart. Licensed Practical Nurse #2 intervenes, wheels Resident #1 to the side, and allows Licensed Practical Nurse to proceed. Video Surveillance footage with no audio dated 08/19/2025, timestamped at 11:55 PM, was reviewed by surveyors in the presence of the Director of Human Resources and the Director of Nursing on 08/25/2025 at 1:26 PM. The footage showed Resident #1 seated in their wheelchair in the doorway of their room while Licensed Practical Nurse #1 stood at the medication cart with their back turned to Resident #1. Licensed Practical Nurse #1 turned around and engaged in a verbal interaction with Resident #1. Resident #1 was observed moving closer to Licensed Practical Nurse #1, both using hand gestures during the exchange. Resident #1 stood up from their wheelchair and sat back down. Shortly after Licensed Practical Nurse #1 was seen moving behind Resident #1's wheelchair and attempted to hold Resident #1's hand down and force him back into their room. Resident #1 was seen resisting and holding on to the frame of the doorway, however, Licensed Practical Nurse #1 continued to attempt to forcefully pull the resident, while the resident was seated in the wheelchair, into the room by holding onto the resident's hands and shoulders, despite the resident resisting. The investigative summary dated 08/20/2025 documented that there is no evidence that any alleged abuse, neglect, or mistreatment had occurred. Review of the Investigative Summary dated 08/20/2025 by surveyors during onsite visit revealed no documented review of the camera footage following the incident on 8/20/25 where the facility concluded that abuse did not occur. During an interview on 08/25/2025 at 5:24 PM the Director of Nursing stated they</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the Abbreviated Survey (2595161) the facility did not ensure that residents received the treatment and care in accordance with professional standards of practice, comprehensive care plan and the resident's choices for 1 (Resident #1) of 3 residents reviewed for pain. Specifically, Resident #1 had a Physician's order for Oxycodone HCL 5 mg orally every 6 hours as needed for pain. Resident #1 on 08/25/2025 revealed on 8/19/2025, they requested their pain medication from Licensed Practical Nurse #1 around 11:54pm because they were in pain. Resident #1 did not receive their pain medication. Resident #1 received their next dose of pain medication at 1:28AM on 08/20/2025, approximately eight hours and thirty-four minutes after the previous administration. The findings are: The facility policy titled Pain Assessment and Management revised on 06/2024 documented assessing pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. Ask the resident if he/she is experiencing pain. Resident #1 was admitted with diagnosis including but not limited to aphasia, cerebral infarction, and hemiplegia and status post revision of right total knee arthroplasty (a procedure that replaces damaged parts of the knee with artificial components made of metal or plastic. The Discharge Minimum Data Set, dated [DATE] indicated that Resident #1 had moderately impaired cognition. The Hospital Discharge summary dated [DATE] documented that Resident #1 had a total knee arthroplasty revision on 07/30/2025. Review of the 08/19/2025 Physician's Order documented that Resident #1 was to receive Oxycodone HCL 5 mg orally every 6 hours as needed for pain. Review of the August 2025 Medication Administration Record documented that Resident #1 last received their pain medication on 08/19/25 at 4:54 PM. The Medication Administration Record further documented that Resident #1 received their next dose of pain medication on 08/20/25 at 1:28 AM, approximately eight hours and thirty-four minutes after the previous administration. Resident #1 initially requested their pain medication on 08/19/25 at 11:55 PM. During an interview on 08/25/2025 at 11:44 am, Resident #1 stated that they were sitting in their doorway in a wheelchair and requested their pain medication from Licensed Practical Nurse #1 due to having significant knee pain. Resident #1 stated that Licensed Practical Nurse #1 appeared very upset and refused to administer their pain medication. Resident #1 further stated that the nurse then began pulling their wheelchair backward, while holding their arms attempting to force them out of the hallway. During an interview on 08/25/2025 at 11:46 AM, a family member of Resident #1 reported that Resident #1 informed them they had requested pain medication but did not receive it promptly. The family member stated that the nurse refused to provide the resident's medications, and they were very concerned due to their recent knee surgery. During an interview on 08/25/2025 at 12:35 PM, Certified Nurse Aide #1 stated they heard yelling in the hallway and recognized raised voices from both Licensed Practical Nurse #1 and Resident #1. Certified Nurse Aide #1 reported hearing Licensed Practical Nurse #1 instruct Resident #1 to return to their room and told them that they could not administer their pain medication and that the night nurse would provide them with their pain medication because they were running late on their medication pass and needed to finish in order to go home. During an interview on 08/25/2025 at 1:33 PM, the Director of Nursing stated that Licensed Practical Nurse #1 reported being behind with medication administration and that multiple residents were requesting medications. The Director of Nursing acknowledged that Licensed Practical Nurse #1 did not provide Resident #1 with their requested pain medication. The Director of Nursing further stated that Licensed Practical Nurse #1 should have assessed Resident #1 for pain and administer the pain medication as ordered by the physician and as requested by the resident. During an interview on 08/26/2025 at 11:07 AM, Licensed Practical Nurse #2 stated that upon arrival for their 12:00 AM-8:00 AM shift, Licensed Practical Nurse #1 was passing medications near Resident #1's room. Licensed Practical Nurse #2 stated that Resident #1 was in their wheelchair in the hallway, yelling at Licensed Practical Nurse #1 for their pain medications. According to Licensed Practical Nurse #2, Licensed Practical Nurse #1 told Resident #1 they were running late and did not have time to administer their pain medications. Licensed Practical Nurse #2 stated that Resident #1 frequently complained of pain related to a recent total knee surgery and that they had never observed the resident become upset about not receiving medications. Licensed Practical Nurse #2 stated they did not observe Licensed Practical Nurse #1 assess Resident #1 for pain. Licensed Practical Nurse #2 further stated that they did not receive the medication cart keys from Licensed Practical Nurse #1 until after 1:00 AM on 08/20/2025. After receiving the keys, Licensed Practical Nurse #2 stated they</p>		