

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335515	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2025
NAME OF PROVIDER OR SUPPLIER Yonkers Gardens Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 115 South Broadway 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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689</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 record review and interviews during abbreviated surveys (NY00378486, NY00339264 and NY00343082), the facility did not ensure that the resident environment remained free of accident hazards and that each resident received adequate supervision for three (3) of three (3) residents (Residents #1 and #2 and #3) reviewed for elopement. Specifically, 1) on 4/20/2025 at approximately 7:00 PM Resident #1 walked unsupervised through the facility's alarmed rear exit patio door through the tunnel to the hospital emergency department, was evaluated and returned to the facility on 4/20/2025 at 11:00 PM in stable condition, and 2) on 04/14/2024 sometime after 7:10 PM Resident #2 exited the facility unsupervised and ambulated to a friend's house, the resident was picked up by facility staff and evaluated at the emergency room and returned to the facility on [DATE] at 11:50 PM in stable condition, and 3) Resident #3 was last seen at the facility on 05/22/2024 at 4:00 PM and was not found until 05/23/2024 by the police. Resident was brought to the hospital and returned to the facility at 5:45 PM on 05/23/2024. The findings are: The facility Security Guard Policy last reviewed January 2024 documented the responsibilities of the security guards included to monitor all facility entrances and exits, verify identification of visitors, ensure visitor log-in procedures are followed, and monitor cameras, alarms, and security systems. Resident #1 was admitted on [DATE] with diagnoses including schizoaffective disorder, cerebral infarct (stroke), and type two (2) diabetes mellitus. The 04/15/2025 Quarterly Minimum Data Set (resident assessment tool) documented Resident #1 had moderately impaired cognition and required supervision with activities of daily living including ambulation. The 04/16/2025 Elopement Evaluation documented that Resident #1 wandered. The 04/20/2025 Incident and Accident Investigation Report documented that Resident #1 was last seen by facility staff on 4/20/2025 at 4:50 PM and their whereabouts were unknown to facility staff on 4/20/2025 at 8:10 PM. The 04/21/2025 facility investigation report documented that Resident #1 exited unsupervised through the facility's alarmed rear exit patio door and walked through the tunnel to the hospital emergency department and documented that the rear exit patio door alarm was going off and the door was open. Wander guard was initiated on admittance to facility however Resident did not have one during the elopement as he refused and removed the prior wander guards. Other interventions in place such as - redirection, initiate code purple if elopement occurs, occupy resident with activities, place name band on admission/readmission, and place resident on frequent checks/monitoring. The Medical Center Patient Information Page documented date and time of Resident #1's arrival on 04/20/25 was at 7:12 PM. The resident was medically cleared and in stable condition on return to the facility. During an interview on 09/08/25 at 1:58 PM, the facility Administrator stated they determined that Resident #1 did not exit during the smoking activity, rather they exited through the rear exit patio door, the alarm went off and the security officer did not respond to the alarm. During an interview on 09/8/25 at 2:25 PM, Certified Nurse Aide #3 stated that on 04/20/2025, they did not look for Resident #1 around 5:30 PM when dinner was served because Resident #1 usually went down to the lobby and came up later for a sandwich or asked them to heat up their dinner later. The Certified Nurse Aide last saw Resident #1 on 4/20/2025 at 4:50 PM. During an interview on 09/8/25 3:36 PM, Licensed Practical Nurse #2 stated they were not worried about Resident #1 because Resident #1 usually went to different floors for activities and went to smoke and stayed in the lobby with his friend in the evenings. During a follow-up interview on 09/8/25 at 4:27 PM, the facility Administrator stated the investigation conclusion was determined from another resident who told the nurse they saw Resident #1 go through the tunnel to the hospital. The Administrator stated they went to the hospital emergency department and the hospital staff told them Resident #1 arrived in the emergency department at around 7:15 PM. The Administrator referenced the Medical Center Patient Information Page which documented the date and time of arrival as 04/20/25 at 7:12 PM. On 09/11/2025 at 11:13 AM, a voicemail was left for Security Guard #1. No return call was received. On 09/11/2025 at 11:17 AM, a voicemail was left to Security Guard #2. No return call was received. Resident #2 was admitted on [DATE] with diagnoses including schizophrenia, alcohol abuse, traumatic subdural hemorrhage without loss of consciousness, and type two (2) diabetes mellitus. The 4/13/2024 Minimum Data Set admission assessment documented Resident #2 had moderately impaired cognition, no behavioral symptoms, and no wandering behavior. The resident had no functional limitations in range of motion, utilized a wheelchair, required partial/moderate assistance with toileting, hygiene, dressing, footwear, personal hygiene, rolling in bed sit to stand transfers. Ambulation did not occur. The 04/14/2024 Incident and Accident</p>		