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 02/12/2026
NAME OF PROVIDER OR SUPPLIER Yonkers Gardens Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 115 South Broadway Yonkers, NY 10701	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observations and interviews conducted during the recertification survey from 2/5/2026 to 2/12/2026, the facility did not ensure that food was stored, prepared and distributed in accordance with professional standards for food safety practice. The facility also did not maintain essential kitchen equipment in a clean and sanitary condition. Specifically, observations revealed expired food items stored in the walk-in refrigerator. An opened and uncovered box of frozen vegetables was observed in the walk-in freezer. Sandwiches and cold cuts prepared for distribution were wrapped in plastic but lacked proper labeling. The glass doors of the countertop hot box food warmers were observed to be covered with large brown and black accumulations of burned grease. During tray line observation, the cook was not wearing a beard covering. A Food Service Worker was observed using unlabeled bottles of grape jelly in food preparation. The faucets at the pot wash sink were observed to be dripping despite being turned off. The floor area adjacent to the hot box warmers was observed to be slippery. The findings include:The facility policy and procedure, Food Storage-Perishable reviewed on 11/2004, documented all food stored in the refrigeration units will be in covered containers or otherwise suitably protected.The facility policy and procedure, Labeling and Dating reviewed on 03/2010, documented all bulk pre-packaged prepared items, i.e. mayonnaise, salad dressing, barbecue sauce, will be marked with an open date and discarded per the manufacturer's expiration date.During an initial tour of the kitchen on 2/5/2026 at 09:48 AM conducted with the Clinical Nutrition Manager, the following observations were made:In the walk-in refrigerator, three (3) 10-pounds plastic containers of sour cream with an expiration date of 1/19/2026 were observed. A half-gallon container of unsweetened Almond Breeze with an expiration date of 1/24/2026 was also present. Additionally, sandwiches and cold cuts prepared for distribution were wrapped in plastic but lacked appropriate labeling.Observation of the walk-in freezer revealed an opened and uncovered box of diced butternut squash. A bag of Tyson breaded white chicken patties was observed outside of its original box and without an expiration date.During observations on 2/5/2026 at 10:16 AM, on 2/11/2026 at 11:56AM and on 2/11/2026 at 3:12 PM the faucets at the pot wash sink were observed dripping despite being turned off. The glass doors of the countertop hot box food warmers were covered with large brown and black accumulations of burned grease. The floor area adjacent to the hot box warmers was slippery.During observation on 2/5/2026 at 10:17AM Food Service Worker #26 was using unlabeled bottles of grape jelly in food preparation.During an interview on 2/5/2026 at 10:18AM Food Service Worker #26 stated that once a grape jelly bottle becomes empty, they remove the original product label, wash the bottle, and refill it with regular grape jelly.During an interview on 2/5/2026 at 10:20AM Clinical Nutrition Manager stated that employees were not permitted to use unlabeled bottles or refill containers with different products for food preparation. The Clinical Nutrition Manager stated the unlabeled bottles would be discarded.During tray line observation on 2/5/2026 at 10:35AM [NAME] #8 was not wearing a beard covering.During an interview on 2/5/2026 at 10:36AM [NAME] #8 stated they were supposed to wear beard covering but forgot to put it on.During an interview on 2/11/2025 at 3:35PM, the Food Service Director stated that in their absence, kitchen supervisors and the [NAME] President of Operations checked stored products for (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335515	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yonkers Gardens Center for Nursing and Rehab	115 South Broadway Yonkers, NY 10701

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	expiration dates on a daily basis. The Food Service Director stated that when present in the facility, they conduct daily in-services regarding storage, food preparation, and monitoring of expiration dates. The Food Service Director stated they were not aware that unlabeled bottles were being reused. The Food Service Director stated that the kitchen was to be cleaned after each food preparation and that verbal work orders were submitted to the maintenance department for any malfunctioning equipment, including leaking faucets.10NYCRR 415.14 (h)

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	335515	A. Building B. Wing	02/12/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification survey from 02/05/2026 to 02/12/2026, the facility did not ensure the resident's right to a safe, clean, comfortable and homelike environment on (2) two of (5) five resident floors (floors 3 and 4). Specifically,1) resident room/s on floor 3 had bathroom fixtures in disrepair, bedroom furniture, doors/walls with stains/scratches, and a soiled stained mechanical lift, and 2) resident room/s on floor 4 had a clock hanging off the wall, a damaged radiator, patched and mismatched wall paint, stained and warped ceiling tiles, dried rust-colored stains on walls/radiators, and a resident hall bathroom on floor 4 had a soiled and stained privacy curtain. The findings include:The policy titled Homelike Environment dated 11/30/2025 documented the facility will provide housekeeping and maintenance services as necessary to maintain a sanitary environment. During observation from 02/05/2026 at 10:08 AM to 02/11/2026 at 3:05 PM the bathroom in room [ROOM NUMBER] had missing wall tiles behind the toilet, and the toilet seat was peeling and cracked. In room [ROOM NUMBER] the dresser had broken and missing drawers, a closet door with a detached loose doorknob was hanging off the track, the wall and door had dried food stains. A mechanical lift on floor 3 had dried brown streaks and dust and grime on the bottom metal base.During observation from 02/05/2026 at 10:34 AM to 02/10/2026 at 11:54 AM in room [ROOM NUMBER], a clock was hanging off the wall from a wire, the top right portion of the radiator was damaged/missing and the wall adjacent to the radiator had large white patches that did not match the wall color. The privacy curtain in the resident hall restroom had brown stains on floor. In room [ROOM NUMBER] the ceiling tiles were warped/stained, the ceiling down to and including the radiator had large streaks of rusty brown dried stains running from the ceiling down to the room's radiator was also covered with rusty brown dried stains.During interview on 02/10/2026 at 11:35 AM, the Director of Maintenance stated their department's job responsibilities included painting, plastering, repairing any broken items and furniture throughout the facility, and repairing ceiling tiles. The Maintenance Department received work order requests and tracked the work they did through a facility-wide computer application available for any staff member to report repair needs. The Director of Maintenance stated they performed daily rounds on each unit and spot-checked residents' rooms to see if there were any repair needs that had not been reported. They stated there has been a significant improvement to the facility's environment since they began working for the facility 6 months ago. After observing the floor 3 and 4 environmental concerns, the Director of Maintenance stated none of these issues were reported to them by staff on the units and they missed these issues on their previous rounds.During interview on 02/10/2026 at 3:47 PM, the Director of Housekeeping stated they ensure cleanliness of resident rooms by making visual rounds on each unit multiple times throughout the day and ensuring their staff were performing their duties and had enough supplies. The Director of Housekeeping stated the facility staff called them or their staff directly when housekeeping was needed to address soiled areas or items. Each unit had a schedule of terminal cleaning for resident rooms where all items were cleaned, including the beds. During interview on 02/12/2026 at 8:20 AM, Housekeeper #25 stated they were assigned to floor 3 on the day shift and their responsibilities included cleaning resident rooms, furniture, bathrooms, and floors. They stated floor 3 was challenging because it was the dementia unit. Housekeeper #25 stated they were not responsible for cleaning the doors or walls of the residents' rooms or hallways. They stated an evening housekeeper was previously assigned to clean the unit hallways and doors and to clean mechanical lifts, wheelchairs, and other resident equipment, but that position was eliminated in 10/2025. Housekeeper #25 stated those duties have not been assigned to any other staff.During interview on 02/12/2026 at 10:51 AM, floor 3 and 4 Nursing Supervisor and Registered Nurse #3 stated they performed rounds daily on each unit and reported any (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	environmental concerns to the Maintenance Department using the facility's computer program and called the Director of Maintenance directly to report urgent repair needs. They stated all nursing staff on the unit were responsible for communicating with the housekeeping staff when resident areas needed to be cleaned. The Housekeeping staff were also responsible for cleaning resident equipment10 NYCRR 415.5(h)(2)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification survey from 02/05/2026 to 02/12/2026, the facility did not ensure residents unable to carry out activities of daily living received necessary services to maintain good grooming and personal hygiene for three (3) of six (6) residents (Resident #11, #7, and #78) reviewed for activities of daily living. Specifically, 1) Resident #11 was not provided with staff assistance to perform facial hair grooming, 2) Resident #7 was not provided with staff assistance to take showers, and 3) Resident #78 was not provided with staff assistance to shower or groom their facial hair.The findings are:The facility policy and procedure, Activities of Daily Living Total Care last reviewed on 12/2025, documented all caregivers, nurses, and staff involved in the direct care of residents or patients who require assistance with activities of daily living, including but not limited to assist with oral care, hair care, shaving, nail care, and other grooming activities. 1) Resident #11 was admitted to the facility with diagnoses including non-Alzheimer's dementia, schizophrenia and depression. The Minimum Data Set (resident assessment) dated 12/14/2025 documented Resident #11 had moderately impaired cognition and needed partial assistance from staff with personal hygiene, and substantial assistance with toileting hygiene and shower/bathe self. The Comprehensive Care Plan for Activities of Daily Living, last updated on 12/22/2023, documented Resident #11 required partial assistance of one person with personal hygiene. During observations and interviews on 02/05/2026 at 1:41 PM and on 02/06/2026 at 10:06 AM , Resident #11 was ambulating in the hallway with long, unshaven facial hair. During an interview, the resident stated that one specific staff member shaved their face, however the resident was unable to recall when their face was last shaved. The resident stated that they preferred to be clean-shaven and stated that they were waiting for that staff member to provide shaving assistance. During interview on 02/11/2026 at 12:16 PM Certified Nurse Aide #6 stated that they were assigned to provide care for Resident #11 approximately two to three times per week, which included assistance with personal hygiene. Certified Nurse Aide #6 stated that each time they assisted the resident, they assess grooming needs, including facial hair that may require shaving, as the resident was unable to shave safely and independently. Certified Nurse Aide #6 stated that grooming activities, including shaving, fall within their responsibilities. Certified Nurse Aide #6 stated that the last time they were assigned to Resident #11 was on 02/06/2026, and on that date they were busy with providing showers to other residents and were unable to shave the resident. Certified Nurse Aide #6 stated that the resident's facial hair was currently too long to be shaved with a razor and would need to be trimmed with a shaving machine or scissors prior to shaving. Certified Nurse Aide #6 stated that they could not remember when the resident was last shaved. Certified Nurse Aide #6 stated that today, they offered to shave the resident, but the resident refused. Certified Nurse Aide #6 stated that when a resident refused care, they reported the refusal to the nurse. During an interview on 02/11/2026 at 12:36 PM, Registered Nurse #7 stated that certified nurse aides were responsible for grooming activities, including facial hair that required shaving. Registered Nurse #7 stated that they had not received report from Certified Nurse Aide #6 regarding Resident #11 refusing care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident # 7 had diagnoses including hypertension, hepatitis and major depressive disorder. The Minimum Data Set (an assessment tool) dated 01/15/2026 documented that Resident # 7 had slightly impaired cognition and was dependent on staff for oral hygiene, toileting and shower/bathe self. The comprehensive care plan for Occupational Therapy, last updated 01/06/2026 documented that the resident was dependent on staff for hygiene/grooming, bathing tasks and transfers. The comprehensive care plan for Activities of Daily Living, last updated on 01/10/2026 documented that the resident was dependent on staff daily in meeting activity of daily living needs. During an interview and observation on 02/05/2026 at 11:00 AM, Resident #7 stated they had not had a bath or a shower for a very long time. They stated that they only received a bed bath, and they wanted to wash their hair. During this observation, the resident's appearance was consistent with her statement as her hair appeared to be unwashed. During an interview on 02/11/2025 at 12:06 PM, Certified Nursing Aide # 13 stated that the resident had not received a shower since their admission. They stated that every time they offered the resident a shower, they refused. During an interview on 02/12/2026 at 9:35 AM Registered Nurse # 3 Unit Manager stated that they could not recall any report of the resident not getting a shower. Additionally, they stated that the charge nurse should have documented if the resident refused a shower. A record review of the Certified Nursing Aide accountability record for January 2026 and the month of February 2026 did not document that the resident ever refused a shower. 3) Resident #78 had diagnoses of dementia and hydrocephalus. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #78 was severely cognitively impaired, did not exhibit any rejection of care, had bilateral functional limitation in range of motion to upper and lower extremities, totally dependent on staff for transfers in and out of bed, shower transfers, bathing, and personal hygiene. No mobility devices were used with Resident #78 within the assessment period. The Comprehensive Care Plan related to skin impairment initiated 06/02/2022 and last revised on 08/22/2025 documented Resident #78 had fragile skin and decreased mobility. Interventions to ensure Resident #78's skin remained intact included moisturizing the skin daily and getting out of bed daily. The Comprehensive Care Plan related to activities of daily living created 06/07/2022 and last revised 02/02/2026 documented Resident #78 required a left-hand roll. There was no documented evidence that care planning interventions were developed and implemented to address Resident #78's dependence upon staff to perform personal hygiene, transfer, and bathing activities. The Certified Nurse Aide Instructions documented Resident #78 required two people and mechanical lift to be transferred out of bed to a recliner and was dependent on staff to perform personal hygiene, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathing, and shower transfers. On 02/05/2026 at 10:25 AM and 02/06/2026 at 11:57 AM, Resident #78 was observed in a hospital gown in bed with unkempt greasy hair and a full scraggly beard. On 02/06/2026 at 12:14 PM, a telephone interview was conducted with the Resident #78's Designated Representative and they stated Resident #78 should be transferred out of bed daily, showered in the shower room twice weekly as scheduled, and clean shaven. The Designated Representative stated they were unable to travel to the facility but attended a care planning meeting and expected staff to provide Resident #78 with activity of daily living assistance whether they were able to visit or not. On 02/09/2026 at 11:02 AM, 12:34 PM, and 1:00 PM, Resident #78 was observed in bed in hospital gown with a full scruffy beard. On 02/11/2026 at 11:38 AM, Certified Nurse Aide #6 was interviewed and stated they were assigned to Resident #78 who required the total assistance of two staff to perform bathing, transfers in and out of bed, and personal hygiene. Certified Nurse Aide #6 stated Resident #78 had severe cognitive impairments, was calm and cooperative during care, and did not refuse care. Resident #78 was scheduled to come out of bed for a shower today but Certified Nurse Aide #6 stated the resident received a bed bath this morning instead. Resident #78's hair continued to look disheveled and greasy because Certified Nurse Aide #6 stated they slightly wet Resident #78's head and then dried the resident's hair with another towel. Certified Nurse Aide #6 stated they did not get Resident #78 totally wet because the water was cold, they didn't want the resident to be uncomfortable. Certified Nurse Aide #6 stated the 3rd Floor did not have a shower stretcher to accommodate Resident #78's positioning needs while showering. On 02/12/2026 at 10:51 AM, 3rd Floor Nursing Supervisor, Registered Nurse #3, was interviewed and stated the charge nurse on the unit was responsible for overseeing the Certified Nurse Aides and the care provided to residents. Registered Nurse #3 stated they and the Director of Nursing were responsible for overseeing the charge nurses. Registered Nurse #3 stated they did not audit chart documentation, and the Director of Nursing would run a report or check to ensure nursing documentation accurately depicted the services provided to the residents. Registered Nurse #3 stated they were not aware of Resident #78's out of bed schedule; however, Resident #78 should be clean shaven and Registered Nurse #3 stated they have not seen the resident with full facial hair. Registered Nurse #3 stated Resident #78 should be transferred out of bed for showers and every floor had a shower stretcher available. Registered Nurse #3 stated new shower stretchers were just purchased for the whole facility and none of the 3rd Floor staff reported there was any issue with providing Resident #78 with a shower. Resident #78 would be receiving a new recliner because this was the second time the previous recliner broke. On 02/12/2026 at 1:24 PM, the Director of Nursing was interviewed and stated they were made aware there were some concerns with residents receiving assistance with their activities of daily living. The Director of Nursing stated the charge nurses on the unit supervised the aides and the nursing supervisors supervised the aides and the charge nurses. Certified Nurse Aides were expected to document the assistance they provided a resident and which tasks they performed with the resident. 10 NYCRR 415.12(a)(3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and interview conducted during the 02/05/2026 to 02/12/2026 Recertification Survey the facility did not ensure appropriate storage of medications in accordance with currently accepted professional standards of practice for one (1) of 10 medication carts and two (2) of six (6) medication rooms. Specifically, one (1) medication cart on the 6th floor was observed unlocked and unattended, and one (1) medication room on the 5th floor was observed unlocked/unattended and contained methadone for Resident #119 and #156 that was stored in the same locked cabinet with other narcotics.The findings include:The 12/2025 policy titled methadone use documented the facility will maintain the use of methadone for pain or management of addiction in accordance with state and federal regulations. When methadone is prescribed for narcotic addiction only methadone must be stored separately from other controlled medications in a double locked cabinet designated for that purpose.During observation on 02/05/2026 at 11:15 AM the 5th floor medication room was unlocked. The cabinets over the sink were unlocked and contained medications. During interview on 02/05/2026 at 11:19 AM Registered Nurse Supervisor #17 stated the medication room should have been locked. They stated they did not know why the room would be unlocked. During interview on 02/05/2026 at 12:23 PM Licensed Practical Nurse #15 stated they were aware the medication room should have been locked. During observation and interview on 02/05/2026 at 4:28 PM the medication cart on the 6th floor was in the hall, unlocked and not within the line of sight when Registered Nurse #2 stepped away to enter the medication room. Registered Nurse #2 stated the medication cart should have been locked when they stepped away to get something from the medication room. During observation of the 5th floor medication room on 02/10/2026 at 1:20 PM methadone (a long-acting medication used to treat drug addiction) for Resident #119 and #156 was stored in a double locked cabinet with other narcotics.During interview on 02/11/2026 at 10:00 AM the Director of Nursing stated medication rooms and medication carts should always be locked. They stated there were two (2) locked cabinets in medication rooms. They stated methadone was supposed to be stored separately from other narcotics. They stated they were unaware the staff were storing methadone with other narcotics. During interview on 02/11/2026 at 12:00 PM the Pharmacy Consultant stated the medication rooms should always be locked. They stated methadone should be stored separately from the other narcotics.During interview on 02/12/2026 at 11:09 AM the Medical Director stated staff needed to abide by the rules when storing methadone.10 NYCRR 418.18(e) (1-4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview during recertification survey from 02/05/2026 to 02/12/2026, facility personnel did not ensure linens were handled and stored in a manner to prevent the spread of infection. Specifically, linens and towels were exposed and stored on top of hampers in resident rooms, and dirty linens were on the floor in the 4th and 5th floor shower rooms. The findings include: The policy titled Handling of Linens dated 11/2025 documented the facility will ensure that all linens are handled, stored, processed and transported to prevent the spread of infection. Staff will handle all used linen as potentially contaminated and will bag linen at the point of use. During observation on 02/06/2026 at 9:59 AM clean linens, and towels were stored on top of resident hampers in rooms [ROOM NUMBERS].During observation on 02/09/2026 10:49 AM clean linens were stored on top of the resident hamper in room [ROOM NUMBER].During observation on 02/09/2026 at 10:52 AM dirty linens were in a pile on the floor of the fourth-floor shower room.During observation on 02/09/2026 10:59 AM linens and resident clothing were stored on top of the resident hamper in rooms [ROOM NUMBERS].During observation on 02/09/26 11:02 AM dirty linens, gloves, and socks were on the floor of the fifth-floor shower room.During observation on 02/09/2026 at 11:12 AM a pillow and linens were stored on top of the resident hamper in room [ROOM NUMBER]. Towels were stored on top of the resident hamper in room [ROOM NUMBER]. Gowns were stored on top of the resident hamper in room [ROOM NUMBER].During interview 02/09/2026 at 11:35 AM Registered Nurse Unit Manager # 10 stated Certified Nurse Aides were responsible for bringing linen/s into resident rooms. They stated they were not aware that linen was stored on top of resident hampers. They stated Certified Nurse Aides were responsible for putting dirty linens into the laundry.During interview on 02/09/2026 at 11:46 AM Certified Nurse Aide # 10 stated they were trained on proper storage of linens. They stated linens should be stored in the clean utility room and/or the cart in the hall. They stated they left linens on the laundry bin or a chair in resident room/s.During interview on 02/09/2026 at 3:47 PM the Infection Preventionist stated proper handling of linen was a part of environmental in-service. They stated clean linen was to be stored in carts on units. They stated dirty linen should be bagged/placed in the laundry chute. They stated they did not know why linen was being stored elsewhere.10 NYCRR415.19

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review conducted during the recertification survey from 02/05/2026 to 02/12/2026, the facility did not ensure a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Specifically, 1) the designated smoking area had a substantial amount of cigarette butts and ice and snow covering on the ground, and 2) elevator #1 had damaged wall paneling and air vent grates. The findings includeThe policy titled Homelike Environment dated 11/30/2025 documented the facility will maintain outdoor areas for the safety and access of residents and visitors to ensure grounds, walkways, and entrances are free of tobacco-related waste. During observation on 02/05/2026 at 1:49 PM and 02/06/2026 at 10:00 AM, the designated outdoor smoking area had a large accumulation of snow and ice bordering a narrow-shoveled path from the door of the facility to a group of benches to the left. There were more than 50 cigarette butts littering the ground and mixed in with the ice and snow.During observation on 02/05/2026 at 12:25 PM, elevator #1 had 2 damaged metal air vent grates at the base of the right wall exposed sharp protruding metal prongs. The right wall paneling had a large section broken off at the lower left-hand corner.During interview on 02/10/2026 at 11:35 AM, the Director of Maintenance stated their department's job responsibilities included painting, plastering, repairing any broken items and furniture throughout the facility, repairing ceiling tiles and maintaining safe temperatures in the facility. The Maintenance Department received work order requests and tracked the work they did through a facility-wide computer application available for any staff member to report repair needs. The Director of Maintenance stated they performed daily rounds on each resident unit and did not mention the outdoor patio as part of their responsibility. After observing the damage to elevator 1, the Director of Maintenance stated the elevator was functioning and the air vents were working even though there was damage to the metal grate covers. There were no current plans to repair the wall paneling and metal grates in the elevator.During interview on 02/10/2026 at 3:47 PM, the Director of Housekeeping stated the Maintenance Department was responsible for clearing snow and ice from the outdoor designated smoking area. Housekeeping staff were responsible for sweeping up the cigarette butts in the area but there was no set cleaning schedule in place. The Director of Housekeeping observed the cigarette butts littering the ground of the smoke area and stated there should not be cigarette butts on the floor. They stated they needed to set up a better system for their staff to keep the area clean. The Director of Housekeeping stated they performed daily rounds on the resident units but rarely went to check the cleanliness of the outdoor smoking area.10 NYCRR 415.29

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 02/12/2026
NAME OF PROVIDER OR SUPPLIER Yonkers Gardens Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 115 South Broadway Yonkers, NY 10701	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification and abbreviated surveys (#2669870), from 02/05/2026-02/12/2026 the facility did not ensure an effective pest control program was maintained for 3 (three) of 5 (five) residential floors (4th, 5th, and 6th floor) in the facility. Specifically, a roach was observed in room [ROOM NUMBER], residents and staff voiced complaints regarding roaches and mice, and the pest control company logs for the past 6 (six) months documented the ongoing presence of roaches on the resident units.Findings include:During an interview on 02/05/2026 at 9:56 AM, Resident #209 stated when they were in the bathroom they saw cockroaches on the floor. During an interview on 02/05/2026 at 10:14 AM, Resident #92 stated there were a lot of mice and roaches. They stated they told the housekeeper and the housekeeper said they could not do anything about it.During an observation on 02/06/2026 at 9:59 AM, there was a pest trap, with dead bugs stuck on, in room [ROOM NUMBER] under the heating unit. During an interview on 02/06/2026 at 10:18 AM, Resident #16 stated they had seen roaches in their bathroom. On 02/06/2026 at 11:06 AM, Resident Council Meeting was held with 16 residents in attendance. Four (Resident #66, #93, #115, and #110) stated they reported issues with roaches and rats during the resident council meetings and pest control efforts were ineffective. During an observation on 02/10/2026 at 12:39 PM, there was a roach on the floor under a resident overbed table in room [ROOM NUMBER].A review of the facility Pest Control Log from September 2025 to February 2026 documented pest concerns related to roach and mice infestation. The Pest Control Log documented the roach infestation was ongoing. The Pest Control Logs documented on, 09/07/2025, 10/08/2025, 10/10/2025, 10/17/2025, 10/31/2025, 11/03/2025, 11/04/2025, 11/13/2025, 11/14/2025, 12/08/2025, 12/13/2025, 12/26/2025, 1/14/2026, 1/19/2026, 1/23/2026, roaches and bugs were observed on the unit. During an interview on 02/12/2026 at 9:51 AM the Administrator stated they were aware of the issues regarding roaches and mice being seen on the units. They stated In December of 2025 they increased the pest control to 2 visits per week. They stated they had not discussed the pest problem as part of the Quality Assurance Performance Improvement program.During a phone interview on 02/12/2026 11:20 AM Office Manager at the pest control company stated they had an active contract with the facility, did site visits and recently increased visits to twice a week. They were aware of pest sightings and changed chemicals to increase effectiveness. They were aware that the facility continued to have roaches and mice.During an interview on 02/12/2026 at 11:53 AM, Certified Nurse Aide #22 stated the unit had an ongoing problem with roaches, they thought the pest control company came about once a month, they had not noticed any improvement.During an interview on 02/12/2026 at 11:56 AM, Certified Nurse Aide #21 stated they had seen roaches in residents' rooms and told management. 415.29(j)(5)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview during a recertification survey from 02/05/2026 through 02/12/2026, the facility did not ensure dignity was maintained for one (1) of four (4) residents (Residents #181) reviewed for dignity. Specifically, the phlebotomist drew blood from Resident #181 in the dining room area where residents were waiting for lunch. The findings include:Resident # 181 was admitted with diagnoses that included but not limited to cerebral infarction, epilepsy and hypertension.Resident Rights policy last reviewed May 2025 documented for any procedure that involves direct resident care, provide for the resident's privacy.The 12/15/2025 Minimum Data Set admission assessment documented Resident #181 was cognitively impaired, no behavior.During an observation on 02/06/2026 at 12:49PM, in the dining room where residents were waiting for lunch, a phlebotomist was observed with their tray of supplies in front of Resident # 181. The phlebotomist was observed removing the resident's left sweater sleeve and drew blood from Resident #181's left arm. The phlebotomist walked to another table in the dining room and placed their tray of supplies in front of another resident. Registered Nurse Unit Manager #19 arrived at the dining room and spoke to the phlebotomist and told them to leave the dining room. When interviewed, Registered Nurse Unit Manager #19 stated the phlebotomist should have asked staff to take Resident #181 to the room and draw the blood in Resident #181's room. 10 NYCRR 415.3.(c)(1)(i)

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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. Based on observations, record reviews and interviews during the recertification survey from 2/5/2026 to 2/12/2026 the facility did not promote and facilitate resident self determination through support of the resident's choices for one (1) of five (5) residents (Resident #7) reviewed for Choices. Specifically, Resident # 7 was not allowed to choose their bedtime. Findings include:Resident # 7 had diagnoses including hypertension, hepatitis and major depressive disorder. The admission Minimum Data Set (an assessment tool) dated 5/27/2025 documented that resident # 7 had intact cognition and it was somewhat important to the resident to be able to choose their bedtime.The comprehensive care plan for Behavior Disturbance last updated 01/10/2026 documented to give the resident as many choices as possible about care and activities.During an interview on 02/10/2026 at 12:32 PM, the resident stated that the staff tell them when they have to go to bed. They stated that they did not like to go to bed early and it was their preference to stay up later. Additionally, they stated that they did not feel free in the facility and they were not given choices.During an interview on 02/11/20926 at 12:06 PM, Certified Nursing Aide # 13 stated that the next shift of aides got mad when residents were still up. They stated that if it was close to shift change, they would tell the residents they had to go to bed now. They stated that if the resident was able to get themself in bed they could stay up, but if they were unable to get themself to bed then they must go into bed.During an interview on 02/12/2026 at 9:35 AM Registered Nurse # 3 Unit Manager stated that the resident must be in bed by the change of shift because they were on hourly monitoring for a fall risk. Additionally, they stated that the resident had to go to bed early because they were non-ambulatory.415.5(b)(1-3)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification survey from 02/05/2026 to 02/12/2026, the facility did not ensure quarterly statements of the resident's financial record were made available for (1) one of (2) two residents (Resident #78) reviewed for Personal Funds. Specifically, there was no evidence quarterly statements of Resident #78's personal funds account was provided to the resident's Designated Representative. The findings include:Resident #78 had diagnoses of dementia and hydrocephalus.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #78 had severe cognitive impairment and their family participated in the assessment. On 02/06/2026 at 12:14 PM, a telephone interview was conducted with Resident #78's Designated Representative and they stated they used to receive quarterly statements of Resident #78's personal funds account activity until approximately 18 months ago. The Designated Representative stated they called the facility's business office multiple times and had to request copies of Resident #78's personal funds account statements. The Designated Representative expressed their concern to the facility's business office, but the facility has not changed their accounting practices. The Resident Account Statement as of 02/10/2026 documented Resident #78 had their funds managed by the facility since 08/10/2023. There was no documented evidence Resident #78's personal funds statements were made available to the residents' Designated Representative quarterly. On 02/12/2026 at 12:16 PM and 1:55 PM, the Medicaid Coordinator was interviewed and stated they were responsible for providing quarterly account statements to cognitively intact residents in the facility. The facility's corporate business office, located off-site, was responsible for sending quarterly statements to the designated representatives of residents with cognitive impairments. The Medicaid Coordinator stated they contacted their corporate business office and were unable to provide any documented evidence Resident #78's quarterly account statements were provided to the Designated Representative.10 NYCRR 415.26(h)(5)(ii)(a-c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during the recertification and abbreviated (2584489) survey from 02/05/2026 to 02/12/2026, the facility did not ensure that alleged violations involving abuse, mistreatment, or neglect were thoroughly investigated for one (1) of five (5) residents. (Resident #140) reviewed for abuse. Specifically, for Resident #140 there was no documented evidence the facility conducted a complete and thorough investigation, including statements, after Resident #140's family member reported the resident was beaten in the shower by certified nurse aides. ^^^^ The findings include: The facility policy and procedure on Abuse Prevention, revised 12/2025, were documented to provide a proactive and systematic approach to protecting residents' rights from harm related to abuse, neglect, or misappropriation of property. The facility protected residents' rights to be free from physical abuse and ensured that residents were not subjected to abuse by anyone, including but not limited to facility staff, residents, consultants or volunteers, and visitors. Reporting of abuse incidents, investigations, and facility response were directed to the New York State Department of Health.Resident #140 was admitted with diagnoses including diabetes mellitus, depression, and epilepsy.The annual Minimum Data Set (an assessment tool) dated 05/09/2025 documented that the resident had moderately impaired cognition and no behavioral issues. Resident # 140 required partial/moderate assistance for showering. Resident #140's comprehensive Care Plan for risk of potential verbal, physical, or sexual abuse, neglect, or mistreatment was initiated on 07/27/2024 and last updated on 08/29/2025, with goals that the resident would not experience any form of abuse or neglect.Register Nurse #3's progress note dated 08/06/2025 at 10:32 AM, documented around 10:09 AM the resident was in the hallway asking for help and unable to put his pantson. This was not their baseline; they were pale with altered mental status and stated they had a seizure. The resident's oxygen saturation was 66% on room air. They were administered oxygen and transferred to the hospital.A nursing progress note dated 08/06/2025 at 11:57 PM documented the resident was admitted to the hospital with a diagnosis of pulmonary emboli (blockage of lung artery from blood clot).The Facility Reported Incident submission to the New York State Department of Health (State Agency) dated 08/07/2025 at 7:48 PM, documented that Resident #140's family came to the facility on [DATE] at 6:40 PM and alleged that the facility's certified nurse aides punched the resident in the head, face, arms, and legs on 08/06/2025 in the morning. The family member stated that the certified nurse aide let the resident fall to the floor and forced the resident to take a cold shower; this was told to the family member by the resident. The resident was in the hospital on [DATE] being treated for a pulmonary embolism. Prior to the hospital transfer, the resident was seen in the hallway asking for help to put their pants on and was observed to be pale and not at their baseline. There was no report of physical abuse as alleged by the family. In addition, the resident did not have any bruises or injuries observed at the time of transfer to the hospital. So far, there is no substantial evidence to support the allegation. The resident's statement related to their condition could not be obtained.A description of the facility's investigation findings documented on 08/07/2025 that no staff or individuals witnessed the incident and that there were no staff by the name Raji in the facility or on the resident's unit. The Director of Nursing documented that statements were obtained from staff who worked the floor on 08/06/2025 on the day shift. Prior to the resident's transfer, the resident did not report any incident as claimed by Resident #140's family.The Nursing Home Investigative Report submitted to the State Agency on 8/14/2026 documented no staff witnessed the incident and that there was no staff by the name the resident's family member had reported. The report documented that statements were obtained from staff who worked on the floor on 08/06/2025 on the day shift. The report documented that prior to the resident's transfer to the hospital, the resident did not report any incident as claimed by the resident's family. The Registered Nurse Manger of the 4th floor and the unit nurse did not witness nor have knowledge of the alleged (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident. The investigation was done by interviewing staff and residents present on the fth floor on 08/06/2025 to establish whether an unusual incident took place prior to Resident #140's transfer to the hospital. Records were also reviewed to find out if there were unusual observations that might support the suspicion of abuse. During an interview on 02/09/2026 at 8:25 AM, Resident #140 stated they remembered being forced to take a shower and being beaten by two staff members, who grabbed them, took their clothes off, and showered them. Resident #140 stated they screamed and yelled. They stated that the two aides gave them the shower after they had beaten them. During a telephone interview on 02/09/2026 at 11:28 AM, the family representative for Resident #140 stated the resident had an incident in which staff beat them in the shower room and gave the resident a cold shower.During an interview on 02/09/2026 at 1:50 PM, Certified Nurse Aide #1 stated they were not aware of the resident being beaten by staff in the shower room. They stated the resident showered on Tuesdays and Fridays during the day shift. They also stated this was their permanent assignment taking care of the resident and they were not asked to write a statement. During an interview on 02/09/2026 at 1:57 PM, Certified Nurse Aide # 14 stated they were not aware of the resident being beaten by any staff during a shower. They stated this was their regular unit and that the resident was not on their assignment. During an interview on 2/09/2026 at 2:10PM, Registered Nurse Unit Manager #3 stated they were not aware of Resident #140 having altercations involving staff or other residents. They stated the resident got along well with everyone. During an interview on 02/09/2025 at 2:25 PM, the Director of Nursing stated there was an allegation by Resident #140's family that the resident was hit by a specifically named person and the did not have staff by that name. They stated the resident was in the hospital when the family reported this incident. They stated the process of reporting incidents to the State Agency was for any witnessed or alleged incident of verbal or physical abuse that the staff were trained on. They stated incidents such as resident-to-resident altercations, abuse, burns, and resident elopement were all reportable. They stated an internal investigation would follow, involving interviews with staff and residents, including written statements, and a complete investigation summary would be produced within 5 days to rule out any allegations of mistreatment and to report the findings to the State Agency. When requested, the Director of Nursing was unable to provide the statements provided during interviews or written statements. During an interview on 2/10/2026 at 12:20 PM, the Administrator stated there were staff statements from the investigation on 8/7/2025. They stated it was unsubstantiated because the certified nurse aide named by the family was not a staff member of the facility. They stated that the Director of Nursing called all staff who were on duty that day, and that they did not witness any incident. They stated that the resident was sent to the hospital for an unrelated issue. They stated that the Director of Nursing spoke to all the staff by telephone but did not have written statements. 10 NYCRR 415.4(b)(3) ^^^^

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on record review and interview conducted during the recertification survey 02/05/2026 - 0212/2026 the facility did not ensure a significant change Minimum Data Set assessment was completed within the 14-day requirement for one (1) of six (6) residents (Resident #2) reviewed for Nutrition. Specifically, a significant change Minimum Data Set was not initiated within 14 days for Resident #2 who had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, a decline in activities of daily living, a decline in cognition and a decline in urinary continence. The findings include:The October 2025 policy and procedure titled Minimum Data Set documented ensure accurate and timely completion of the Minimum Data Set in accordance with the State and Federal Operation Manuals. Assessments will be completed by members of the interdisciplinary team in accordance with the completion date as determined by the Minimum Data Set Director. For comprehensive assessments that require completion of Care Area Assessments all disciplines will be required to complete the Minimum Data Set as assigned.Resident #2 was admitted with diagnoses that included but were not limited to cerebral infarction with hemiplegia and hemiparesis affecting left non-dominant side, and stage 3 chronic kidney disease.Resident #2's weights documented 9/6/2025 178.0 lbs. 10/5/2025 165.0 lbs.11/24/2025 147.0 lbs.The 11/29/2025 Medicare 5-day Minimum Data Set assessment documented Resident #2 had intact cognition, received substantial/maximum assistance for eating, was frequently incontinent of urine, and had weight loss of 5% or more in the last month or loss of 10% or more in last 6 monthsResident #2's weights documented 12/8/2025 132.2 lbs. 12/10/2025 134.4 lbs.The 01/05/2026 quarterly Medicare 5-day Minimum Data Set assessment documented Resident #2 had impaired cognition, was dependent on staff with eating, was always incontinent of urine, and had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months.Resident #2's weight documented 01/16/2026 130.2 lbs. The 01/23/2026 dietitian note documented 01/2026 monthly weight 130.2 lbs. significant 21% weight loss x 3 months. Resident with multiple hospitalizations during this time, receives Remeron, goal to prevent further weight loss, current diet puree, suboptimal by mouth intake, received ensure plus 8 ounces 3x a day to aid with weight goal. Resident #2's weights documented 2/2/2026 117.6 lbs.The 02/04/2026 dietitian note documented significant weight loss 9.6% x 1 month, 20% sig wt. loss x 3 months. staff and Speech Language Pathologist report resident refusing meals with very poor intake. Supplements include ensure plus 8 ounces 3x a day, and prostat 30 cubic centimeter 2x a day.The 02/09/2026 nurse practitioner note documented acute delirium and auditory & visual hallucination, Human Immunodeficiency Virus, Failure to thrive in adult with weight loss and poor oral intake, Urinary Tract Infection contributing to acute mental status change, continue Mirtazapine 15 mg for appetite stimulation and mood support.During an interview on 02/10/2026 at 10:47 AM the Minimum Data Set Coordinator stated they scheduled the Minimum Data Set assessments, reviewed all assessments, and ensured accuracy/completion of assessments. They stated the facility did not have meetings to discuss weights/ weight loss. They stated nursing and dietary determined weight loss. They stated the dietitian filled out the weight section in the Minimum Data Set assessment. They stated they did not review the weight section. They stated they were not aware that Resident #2 had a weight loss. They stated they did not always review previous Minimum Data Set assessments when they completed new assessments. They stated between 11/29/2025 and 01/05/2026 Resident #2 had changes in activities of daily living, urine incontinence, cognition and weight loss. They stated a significant change Minimum Data Set assessment should have been completed when identified.During an interview on 02/10/2026 12:26 PM, the Clinical Nutrition Manager stated they coded the Minimum Data Set section pertaining to weights. The Clinical Nutrition Manager stated they discussed weights during morning meetings. and addressed weight loss in morning meetings with nursing staff. The Clinical Nutrition Manager stated they discussed Resident #2's significant weight loss with the Interdisciplinary team and Minimum Data Set assessment during morning meeting. They stated they (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were unable to recall the exact date of the discussion. The Clinical Nutrition Manager stated the facility did not have a system to review resident weights and did not conduct weight rounds. The Clinical Nutrition Manager stated there should have been a significant change Minimum Data Set assessment based on Resident #2's weight loss and decline in eating, but it was missed.The 02/10/2026 at 12:46 PM Minimum Data Set Coordinator note documented Resident #2 experienced a 9.6% unplanned weight loss in less than 30 days, meeting criteria for significant change in status. They stated this represented a non-self-limiting decline from baseline that required initiation of a significant change assessment to ensure accurate Minimum Data Set coding and appropriate care plan revision.During an interview on 02/11/2026 at 9:20 AM, the Director of Nursing stated Resident #2's weight loss was discussed several times during morning meetings. They stated the Minimum Data Set Coordinator was responsible for checking accuracy and completeness of all assessments. They stated there should have been a significant Minimum Data Set assessment completed at the time when weight loss, activity of daily living change and change in cognition was identified.10NYCRR 415.11(a)(3)(ii)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview conducted during the Recertification Survey from 2/05/2026 to 2/12/2026, the facility did not ensure Minimum Data Set Assessments were submitted within 14 days after the facility completed the resident's assessment for two (2) of two (2) (Resident #83 and #96) residents reviewed for Minimum Data Set. Specifically, Resident #83 and #96's Minimum Data Set Assessments were completed on 10/07/2025, and were not transmitted until 02/09/2026. The findings include:Minimum Data Set Policy and Procedure dated October 2025, documented it was the policy for timely completion of the Minimum Data Set in accordance with the State and Federal Operation Manuals.Review of the submissions revealed:- Resident # 83 Discharge Minimum Data Set 3.0, with an assessment reference date of 09/22/2025 and completion date of 10/07/2025, was transmitted on 02/09/2026.- Resident #96 Discharge Minimum Data Set 3.0, with an assessment reference date of 09/26/2025 and completion date of 10/07/2025, was transmitted on 02/09/2026.During the interview on 02/10/2026 at 10:10 AM, the Minimum Data Set Coordinator stated after reviewing the Minimum Data Set schedule, two assessments were not transmitted, although completed. They further stated another Minimum Data Set nurse had documented an old code from a validation report into the electronic medical record software which indicated the record had been transmitted when it had not.During the interview on 02/10/2026 at 10:14AM, the Administrator stated the Minimum Data Set Coordinator was responsible for ensuring the Minimum Data Sets were completed and submitted timely, they were unaware the assessments were transmitted late.10 NYCRR 415.11

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NAME OF PROVIDER OR SUPPLIER: Yonkers Gardens Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 115 South Broadway 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 conducted during the Recertification Survey from 02/05/2026 to 02/12/2026, the facility did not ensure that the Minimum Data Set assessment accurately reflects the resident's status for (1) one of (3) three residents (Resident # 46) reviewed for Smoking. Specifically, the 12/10/2025 Minimum Data Set assessment was not accurately coded to reflect Resident #46's use of tobacco. The findings include:The October 2025 policy and procedure titled Minimum Data Set documented ensure accurate and timely completion of the Minimum Data Set in accordance with the State and Federal Operation Manuals. The assessments will be completed by members of the interdisciplinary team in accordance with the completion date as determined by the Minimum Data Set Director. For comprehensive assessments that require completion of Care Area Assessments all disciplines will be required to complete the Minimum Data Set as assigned.Resident #46 was admitted with diagnoses that included but were not limited to opioid dependence, acute kidney failure and obesity.The 12/04/2025 care plan for psychosocial history documented Resident #46 is a known smoker.The 12/05/2025 smoking assessment completed by Registered Nurse Unit Manager # 19 documented Resident #46 smoked. The 12/05/2025 smoking contract documented Resident #46's and the Recreation Directors signatures.The 12/10/2025 Minimum Data Set admission assessment (an assessment tool) documented Resident #46 was cognitively intact, had no impairment of the upper extremity, and did not use tobacco. During an interview on 02/05/2026 at 10:43 AM and on 02/06/2026 at 12:26 PM, Resident #46 stated they smoked cigarettes three (3) times a day in the smoking room. They stated their lighter and cigarettes were locked up in the cart downstairs. They stated smoking time was 30 minutes.During an interview on 02/10/2026 at 11:02 AM, the Minimum Data Set Coordinator stated they were responsible for the accuracy and completeness of all Minimum Data Set assessments. The Minimum Data Set Coordinator stated tobacco use should have been coded on the Minimum Data Set assessment. 10NYCRR 415.11(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification survey from 02/05/2026 to 02/12/2026, the facility did not ensure each resident received adequate supervision to prevent accidents. This was evident for one (Resident #19) of three residents reviewed for smoking. Specifically, Resident #19 was not reassessed for their ability to smoke safely and care plan interventions to prevent future noncompliance were not developed and implemented following the resident's noncompliance with facility smoking rules. The findings are:The facility policy titled Smoking dated 05/2025 documented smoking restrictions shall be strictly enforced in all nonsmoking areas. The staff should consult the Director of Nursing and Physician to determine restrictions on a resident's smoking privileges.Resident #19 had diagnoses of adjustment disorder, post-traumatic stress disorder, and nicotine dependence. The comprehensive Minimum Data Set 3.0 assessment dated [DATE] documented Resident #19 was cognitively intact, a smoker, and rejected care. The quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #19 remained cognitively intact and required supervision or setup assistance with activities of daily living.The admission Agreement dated 06/26/2024 and signed by Resident #19 documented the facility was a smoking facility and the resident agreed to abide by the facility smoking rules. The Smoking assessment dated [DATE] documented Resident #19 displayed accurate understanding of the smoking policy and had no history of noncompliance with the smoking rules. Questions regarding Resident #19's ability to follow the smoking policy and whether they had been observed sharing, selling, or asking others for cigarettes were left unanswered on the assessment form. The Comprehensive Care Plan related to smoking created 05/02/2025 documented Resident #19 would be allowed to smoke in the designated areas under supervision, and the smoking policy would be reviewed with the resident as needed. Resident #19's care plan was last reviewed on 12/18/2025 and documented that Resident #19 would accept the facility policy on smoking. The Comprehensive Care Plan related to physical aggression created 05/02/2025 documented Resident #19 had poor impulse control and a history of harming others. Interventions to prevent further risk of harm included increased behavioral monitoring, adequate supervision and monitoring, and removing Resident #19 from distress before their agitation escalated. The care plan was last revised 07/11/2025 and documented Resident #19 was removed from hourly safety monitoring.The Medical Doctor Note dated 09/05/2025 documented Resident #19 was noted with verbal outbursts, antagonistic behavior towards staff and other residents but remained stable. The Social Work Note dated 09/07/2025 documented Resident #19 was agitated following their smoking session and displayed unpredictable threatening behavior placing themselves and others at risk for abuse. The Social Services Interim assessment dated [DATE] documented Resident #19 was a smoker, and the smoking policy and contract were not reviewed or signed with the resident. The Activities Note dated 09/26/2025 documented Resident #19 reportedly smoked in their room. A strong cigarette smell was present, and staff found an empty cigarette box. Resident #19 was educated on the smoking rules and regulations. The Nursing Note dated 09/30/2025 documented Resident #19 had a verbal disagreement with the resident in the adjacent room with whom Resident #19 shared a bathroom. The other resident reported Resident #19 was smoking in the bathroom causing it to smell of cigarettes. The police were called and Resident #19 denied smoking in their room and refused a room change closer to the nursing station. The Social Work Note dated 10/01/2025 documented Resident #19 attended a care plan meeting with the interdisciplinary team and Resident #19's noncompliant smoking behavior and abusive behavior were discussed. A Smoking Contract dated 11/05/2025 documented Resident #19 agreed not to store tobacco or smoking materials in their room or on their person, Cigarette butts must be discarded in the appropriate trash receptacles. The contract also documented Resident #19 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understood they may lose their smoking privileges and be subject to room search if they acted inappropriately.The Social Services Interim assessment dated [DATE] documented the smoking contract was not reviewed with Resident #19 although the resident continued to smoke and displayed agitation. There was no documented evidence Resident #19 was reassessed for smoking ability following episodes of noncompliance and smoking in their room. There was no documented evidence Resident #19's care plan related to smoking was reviewed and revised to include adequate interventions to address Resident #19's smoking noncompliance. There was no documented evidence Resident #19 was provided with supervision and monitoring to prevent further episodes of noncompliance with smoking rules. On 02/05/2026 at 11:27 AM, Resident #19's room was empty with the door open and was observed with a strong smell of stale smoke. A soda can was observed on the baseboard next to the radiator below a window. Cigarette ashes were lying on top of the soda can and the mouth of the can was burned along the edges. There were three brown burn marks on the floor near the resident's bed. At 11:32 AM, Resident #19 was interviewed in their room and stated they violated the smoking policy and smoked in their room several months ago in 2025. Resident #19 stated they have not smoked in their room since then and only had a soda can with ashes because there was no garbage can for them to use in the designated smoking area outside. Resident #19 denied smoking in their room and stated the burn marks on the floor were from previous occasions of smoking in their room. Resident #19 stated the recreation department held onto their cigarette and lighting materials and the facility offered three smoking times per day. On 02/05/2026 at 4:53 PM, Smoke Monitor #26 was interviewed and stated they were responsible for monitoring the designated smoking area while residents smoked during the facility's scheduled smoking throughout the day. The Recreation Department was responsible for holding onto residents' cigarettes and lighting materials in a locked smoking cart that was only brought out during smoking times. The Recreation Director was responsible for reviewing the smoking contract with residents identified as smokers. No residents were allowed to hold onto their own cigarettes or lighting materials, even if they were considered safe smokers. The smoking contract outlined repercussions for residents who violated the smoking rules. Nursing was responsible for assessing residents' smoking abilities. Smoke Monitor #26 stated they have observed residents violate the smoking contract by lighting each other's cigarettes in the designated smoke area but did not report all these violations to their supervisor. Smoke Monitor #26 stated they were unable to adequately monitor all the smokers in the designated smoking area on their own and could not supervise the actions of all the residents throughout the whole session. Smoke Monitor #26 stated they tried to catch and discourage residents from bringing cigarette butts back into the facility at the end of their smoking sessions. After the recent snowstorm, Smoke Monitor #26 stated they observed many residents throwing their cigarette butts on the ground, a violation of the smoking contract, because the designated smoke area was not clear of snow and ice and the residents could not reach the ashtrays. Smoke Monitor #26 stated Resident #19 has been noncompliant with the smoking rules since admission to the facility. There were no special monitoring instructions for Resident #19 when in the designated smoke area. On 02/11/2026 at 11:56 AM, the Recreation Director was interviewed and stated Nursing determined a resident's smoking status upon admission and was responsible for completing the smoking assessment. Nursing then contacted the Recreation Director to educate the residents on smoking cessation, provide the smoking times and rules, and have the residents sign a smoking contract. The smoking assessment included information on the residents' respiratory status, oxygen use, cognition, physical limitations, and history of noncompliance with smoking rules. The Recreation Director stated they were responsible for taking possession of residents' smoking materials and lighters upon admission and securing them in the locked smoking cart. Repercussion for noncompliance with the smoking rules included room searches and smoking ban for 24, 48, or 72 hours. The Recreation Director stated Resident #19 consistently violated the smoking rules by possessing paraphernalia and smoking in their room. Room searches were done by interdisciplinary staff upon each alleged violation and were not a consistent (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention in Resident #19's plan of care. Resident #19 always denied smoking in their room and became agitated and threatening during room searches or conversations with staff regarding smoking noncompliance. Facility interdisciplinary staff discussed revoking Resident #19's smoking privileges but believed this would be a violation of resident rights and continued to allow Resident #19 to smoke. The Recreation Director stated they were not involved in the care plan documentation or most recent smoking assessment. The Recreation Director stated their department used to have a second smoke monitor during smoking times because it was difficult for one person to supervise all the residents during the smoking sessions. The second smoke monitor recently resigned, and the facility would be able to fill that role within the next few weeks to ensure adequate supervision of the designated smoking area. The Recreation Director stated they would be filling in as the second smoke monitor for the time being. On 02/12/2026 at 8:42 AM, the Director of Social Work was interviewed and stated, when available, they were involved in room searches for Resident #19 and care plan meetings to discuss Resident #19's smoking noncompliance. The Director of Social Work stated they were not involved in smoking assessments and was unsure how often they occurred for each resident. Resident #19 received psychological services routinely. The Director of Social Work was unable to find Resident #19's last psychiatry consultation. Resident #19 has been offered a room change closer to the nursing station so unit staff could better monitor the residents for smoking noncompliance; however, the residents refused to have their room changed. The Director of Social Work stated they would have to meet with interdisciplinary department heads and the Psychologist to develop a behavior management plan for Resident #19 that included interventions to address smoking noncompliance. There currently was no plan in place. On 02/11/2026 at 11:11 AM, Certified Nurse Aide #13 was interviewed and stated Resident #19 was known to be noncompliant with the smoking rules and there were several instances of this resident smoking in their room. Each time a staff member or other resident alleged Resident #19 was smoking in their room, the resident's room would be searched and, by the time staff were able to gain access, there were no smoking materials found. Resident #19 only required supervision and setup with activities of daily living and refused to allow anyone in their room without them present. Certified Nurse Aide #13 stated they could not recall the last time they had to report to the supervisor that Resident #19 was smoking in their room. There was no special supervision or monitoring for Resident #19 besides the normal daily hourly visual rounds performed for all residents on the unit. On 02/12/2026 at 10:51 AM, Registered Nurse #3 was interviewed and stated registered nurses were responsible for identifying smokers upon admission, offering residents smoking cessation, assessing a resident's ability to smoke safely, and updating the resident's smoking care plan. Registered Nurse #3 stated they were unsure how often smoking assessments were done for residents and did not believe there was any regularly scheduled reassessment. The interdisciplinary team conducted care plan meetings in line with the Minimum Data Set 3.o assessment schedule and only discussed care plans triggered during the assessment period. Registered Nurse #3 stated they have not personally assessed Resident #19 for smoking safety since 2024. The evening staff have reported Resident #19 smoked in their room. Registered Nurse #3 stated there was no plan in place to more closely monitor Resident #19 due to their noncompliant smoking behavior. Registered Nurse #3 stated the last care plan meeting for Resident #19 did not include discussions about the resident's smoking noncompliance.On 2/05/2026 at 5:52 PM and 02/12/2026 at 1:05 PM, the Director of Nursing was interviewed and stated the nursing staff were responsible for assessing a resident's ability to smoke safely. The Director of Nursing stated they were unsure how often the smoking assessments were conducted by the nursing staff. There was no accident/incident investigation required into Resident #19's alleged noncompliance in 09/2025 because no cigarettes were found in the resident's room during a room search and the resident had no burns. The recreation department staff were responsible for reporting smoking infractions to the rest of the interdisciplinary team during morning report and the social work department was responsible for addressing any inappropriate behaviors or smoking noncompliance. The Director of Nursing stated they were part of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the brainstorming in morning report to develop effective interventions to address smoking noncompliance. The Director of Nursing stated revision to the facility's smoking policy and procedure were necessary and ongoing. 10 NYCRR 415.12(h)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the recertification survey from 02/05/2026 to 02/12/2026, the facility did not ensure a resident who needed respiratory care was provided with such care, consistent with professional standards of practice for one (1) of one (1) residents reviewed for respiratory care. Specifically, Resident #92 had a physician order for oxygen via nasal canula at 4 liters per minute, and was observed receiving oxygen via nasal cannula at a rate of 2 liters per minute. The findings include:Resident #92 had diagnoses that included Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, and Asthma.The Quarterly Minimum Data Set, dated [DATE] documented Resident #92's cognition was intact, the resident required supervision or touching assistance with activities of daily living, and the resident used oxygen.The physician order dated 08/26/2025 documented continuous oxygen at 4 liters via nasal canula. The Oxygen Therapy Care Plan dated 01/26/26 documented oxygen at 4 liters via nasal canula. During observations on 02/05/2026 at 11:51 AM, and 02/09/2026 at 10:27 AM and 12:00 PM, Resident #92 was receiving oxygen via a nasal canula at 2 liters per minute. Resident #92 stated they had been on oxygen at 2 liters for 5 (five) years. During an interview on 02/09/2026 at 12:00 PM, Licensed Practical Nurse #15 stated the resident was on 2 (two) liters of oxygen via nasal canula. They did not check the order every day as it was documented on the Treatment Administration Record. They stated as far as they knew the resident was always on 2 (two) liters. During an interview on 02/09/2026 at 12:20 PM, Registered Nurse Unit Manager #10 stated they were unsure how often the nurse checked the orders for oxygen, and thought it was at least once a shift. They stated oxygen should have been delivered as prescribed in the physician order. During an interview on 02/09/2026 12:31 PM the Director of Nursing stated when a resident was receiving oxygen, the medical provider would write the order to include the liter flow and the delivery method. The unit nurse checked the physician order every shift and the orders were transcribed onto the Treatment Administration Record. They reviewed Resident # 92's Treatment Administration Record during the interview and stated they did not see the order. They did not know why the resident would receive 2 (two) liters of oxygen if the order documented 4 (four) liters. They were unsure why the care plan documented oxygen at 4 (four) liters. If the resident had been on 2 (two) liters for a while, the medical provider should have been consulted regarding the discrepancy. 10 NYCRR 415.12(k)(6)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, and interview conducted during the Recertification Survey and Abbreviated survey (2650146) from 02/05/2026 to 02/12/2026, the facility did not ensure medications were available to meet the needs of each resident for one (1) of three (3) residents reviewed for pain management. Specifically, when Resident #205 was re-admitted to the facility, Methadone was unavailable for timely administration.Findings include:The facility policy and procedure, Methadone Use last reviewed on 12/2025, documented when methadone is prescribed for narcotic addiction only: the resident is certified as a patient of an identified Opioid Treatment Program which will supply the methadone, prior to admission to the facility.Resident #205 was admitted to the facility with diagnoses including opioid abuse with unspecified opioid-induced disorder, anxiety disorder and obstructive uropathy,The Minimum Data Set (resident assessment) dated 10/12/2025 documented Resident #205 was cognitively intact and received opioid medication 7 of 7 days. The 10/6/2025 Physician Order documented Methadone HCl Oral Solution 10 MG/5ML, to give 40 milligrams by mouth one time a day for opioid dependency.The Comprehensive Care Plan, Substance Abuse dated 10/10/2025, documented administer medication as ordered.A nursing note dated 10/13/2025 at 12:15 PM, documented the resident was not feeling well. They were seen by the physician and sent out to the hospital for hypoxia; their oxygen saturation was 88% with oxygen administered at 3 liters/minute. A nursing note dated 10/14/2025 at 2:16 AM, documented the resident was admitted to the hospital with a diagnosis of pneumonia. Registered Nurse Supervisor #4's Admission/readmission progress note dated 10/18/2025 (Saturday) at 8:37PM, documented Resident #205 returned from the hospital with unchanged medications and was started on two (2) antibiotic medications. Physician #1 was made aware of the situation.The Medication Administration Record dated 10/19/2025 revealed order Methadone HCl oral solution 10 MG/5ML to administer 40 milligrams by mouth one time a day was signed by Registered Nurse #5 with chart code See Progress Notes.A medication administration progress notes dated 10/19/2025 at 12:28 PM documented Methadone 40 milligram for opioid dependency was not given and was not on hand. Registered Nurse #5's nursing progress notes dated 10/19/2025 at 2:31PM documented the resident was unable to get methadone since it was not in facility. The resident was yelling and using profanity since they were not able to get medication. Registered Nurse Supervisor #4 and Physician #1 were made aware of the situation.Registered Nurse Supervisor #4's nursing progress note dated 10/22/2025 at 12:08 AM, as a late entry for 10/19/25, documented they were informed by Registered Nurse #5 that Resident #205 did not have a bottle of methadone. Physician #1 was notified and stated that the resident would get methadone from clinic on Monday.During interview on 02/09/2026 at 4:11 PM Registered Nurse Supervisor #4 stated the hospital was expected to notify the facility prior to a resident's discharge to ensure medications, including methadone were available upon re-admission. Registered Nurse Supervisor #4 stated the facility was not notified of the resident's discharge and therefore did not have methadone available at the time of re-admission. As a result, the resident did not receive the scheduled methadone dose on Sunday 10/19/2025. Registered Nurse Supervisor #4 stated the methadone clinic was closed over the weekend. The Physician was notified of the missed dose. During interview on 02/09/2026 at 4:29 PM, the Director of Nursing stated that residents receiving methadone would not be admitted on weekends unless the medication was available. The Director of Nursing stated that the methadone clinic was closed on weekends, and the facility could not accept residents receiving methadone without ensuring medication availability. The Director of Nursing stated that if a resident on methadone were admitted over the weekend without the medication available, the facility would request that the resident returns to the hospital. The Director of Nursing stated that nurses were responsible for resident care and communication. The Director of Nursing did not know whether Resident #205 was offered the option to return to the hospital or refused to do so.During interview on 02/09/2026 at 5:01 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Admissions stated that discharge paperwork was not received from the hospital and that the facility was not notified of the resident's weekend transfer. Director of Admissions stated that they did not work on weekends, however, the hospital could have contacted either the facility's Marketer or the Director of Admissions directly. Director of Admissions stated that no notification was received by anyone at the facility.During interview on 02/12/2026 at 10:39 AM Medical Director stated that they were involved in developing policies and procedures related to methadone management. The Medical Director stated that coordination with the hospital should occur prior to discharge to ensure methadone availability at the facility. The Medical Director stated that a system should be in place for admissions or readmissions of residents receiving methadone, particularly since the methadone clinic may be closed on weekend. 10 NYCRR 415.18(a)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, record review, and interviews conducted during the recertification and abbreviated surveys (2669870), the facility did not ensure a Quality Assurance and Performance Improvement (QAPI) program that put forth good faith attempts to identify and correct quality deficiencies. Specifically, the facility was aware of ongoing sightings of roaches and mice (see F925) and there was no evidence a QAPI plan was in place to to address pest control. The findings include:The Facility Quality Assurance and Performance Improvement Policy, last revised in March 2025, documented establishing a QAPI committee/subcommittee that works in tandem with the facility leadership and the Quality Assessment & Assurance committee.A review of the 2025 Quarterly Meeting Attendance Sheets titled Quality Assurance and Performance Improvement Employee Sign in Sheets for 4/8/2025, 7/23/2025 and 11/12/25 documented topics for discussion.The 4/8/2025 topics/agenda included Quality Assurance and Performance Improvement for Plan of Correction on staffing, dignity, maintenance repairs, accident/incident report, smoking compliance, pressure ulcers, antibiotic stewardship, documentation.The 7/23/2025 topics/agenda included Quality Assurance and Performance Improvement for Plan of Correction on staffing, dignity, maintenance repairs, exercise of rights, smoking compliance, accident/incident reports, pressure ulcers and antibiotic stewardship.The 11/12/2025 topics/agenda included Quality Assurance and Performance Improvement for Plan of Correction on staffing, dignity, maintenance repairs, accident/incident reports.During interviews with staff and residents from 02/06/2026 to 02/10/2026 there were ongoing concerns regarding pest control (see F925). During an interview on 02/12/2026 at 9:51 AM, the Administrator stated they were aware of the issues regarding roaches and mice being seen on the units. They had not discussed the pest problem as part of the Quality Assurance Performance Improvement program.10 NYCRR 415.27(a-c)

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview conducted during the recertification survey from 2/5/2026 to 2/12/2026, the facility did not ensure the Quality Assurance & Performance Improvement Committee consisted at a minimum of the Infection Control Practitioner, the Medical Director, the Administrator and the Director of Nursing. Specifically, the Infection Control Practitioner did not participate in Quality Assurance & Performance Improvement meetings for three (03) out of the three (03) quarterly meetings in 2025. The findings include:The Facility Quality Assurance and Performance Improvement Policy, last revised in March 2025, documented establishing a QAPI committee/subcommittee that works in tandem with the facility leadership and the Quality Assessment & Assurance committee.A review of the Quality Assurance and Performance Improvement Committee members documented the Administrator, Director of Nursing, Director of Social Services, Minimum Data Set Coordinator, Medical Director, Infection Preventionist, and two (02) Registered Nurse Unit Managers.A review of the 2025 Quarterly Meeting Attendance Sheets titled Quality Assurance and Performance Improvement Employee Sign in Sheets for 4/8/2025, 7/23/2025 and 11/12/25 revealed the Infection Control Preventionist did not sign the attendance sheets.During an interview on 02/12/2026 at 01:31 PM, the Administrator stated they held Quality Assurance Performance Improvement meetings quarterly. They stated that the Infection Control Practitioner/Preventionist had not been attending the Quality Assurance Performance Improvement meetings. The Administrator was unable to explain the absence of Infection Control Preventionist for three (3) quarterly meetings in 2025.10 NYCRR 415.27(a-c)