STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335795	A. Building B. Wing	01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andrus on Hudson	185 Old Broadway Hastings on Hudson, NY 10706

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44266 Based on observation, interviews and record reviews conducted during an Abbreviated Survey (NY00326823), the facility did not ensure that a resident's care plan was revised with specific interventions/instructions needed to provide effective and person-centered care for 1 of 4 residents (Resident #3) reviewed. Specifically, Resident #3 fell out of the Hoyer lift on 10/22/2023 during a two person assist transfer, allegedly due to a sudden jerking movement. Resident #3 sustained right forehead superficial laceration, upper arm abrasion and a right wrist skin tear and transferred to the hospital. Resident #3's care plan was not updated with interventions to monitor for sudden movements during transfers or to anticipate unsafe movements. The findings are: Review of the facility Policy and procedure titled, Care Plan Review and Revisions dated 04/14/2023 documented the comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. Resident #3 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis, Major Depressive Disorder and Chronic Pain. The Minimum Data Set (MDS, an assessment tool) dated 09/08/2023, documented that the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 12/15, associated with intact cognition (00-7 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). The facility Accident/Incident Occurrence Report dated 10/22/2023 documented Resident #3 fell out of the mechanical lift during a transfer with two persons assist. Report documented Resident #3 was being transferred from their bed to their wheelchair when Resident #3 made a sudden jerking movement and fell . Resident #3 sustained laceration to right forehead, upper arm abrasion and right wrist skin tear.Residenr #3 was able to move upper extremities,and had no changes in mental status. Report documented Resident #3 denied knowing what occurred and Resident #3's physician and family member were notified. (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 Fall care plan revision dated 10/22/2023 documented interventions applied included immediate local treatment to affected area, head to toe assessment, pain management, physician and family notification, sideline equipment for inspection, change Hoyer lift pad to smaller size and re in- service staff on the use of mechanical device and been vigilant during procedure. There were no documentation of specific interventions addressing/ monitoring for unsafe movements during transfer. During an interview with Staff #4(Registered Nurse) on 12/20/2023 at 12:38 PM, they stated that on 10/22/2023 Staff #3(Certified Nursing Aide) asked to assist with transferring Resident #3 from bed to wheelchair. Staff #4 stated when they were transferring Resident #3 into the chair Resident #3 leaned forward and fell out of the mechanical lift. Staff #4 stated they were so shocked and unsure of how Resident #3 fell . Staff #4 stated they immediately completed an assessment of Resident #3 and notified the physician and family. Staff #4 stated Resident #3 was ordered and transferred to the hospital for evaluation due to a skin tear on the head. During an interview with Staff #3(Certified Nurse Aide) on 01/02/2024 at 5:35 PM, they stated on 10/22/2023 after caring for Resident #3 they asked Staff #4 for assistance with mechanical lift transfer. Staff #3 stated they had Resident #3 in the mechanical lift and were guiding them into the wheelchair. Resident #3 made a sudden jerking movement and fell out of the mechanical lift on the floor. Staff #3 stated Staff #4 immediately attended to Resident #3 while they went to get additional assistance. Staff #3 stated Resident #3 was sent out the hospital for evaluation. Staff #3 stated they could not explain how Resident #3 jerked out of the mechanical lift. After the incident they were re in serviced on the safety/use of mechanical lifts. During a telephone interview on 01/02/24 at 2:02pm with Staff #5(the Assistant Director of Nursing, they stated that the care plan for Resident #3 should have been updated with interventions addressing monitoring for jerking and sudden unsafe movements during transfer. Staff #5 stated they in serviced all staff to be more vigilant of the sudden movements but forgot to update the care plan. 10 NYCRR 415.11 (c)(2)

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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 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** 44266 Based on observations, interviews and record review conducted during an abbreviated survey (NY00328308, NY00317607) the facility did not provide adequate supervision/monitoring to prevent accidents for 2 of 4 residents (Resident #1 and Resident #2) reviewed. Specifically, Staff #1(Certified Nursing Aide) was scheduled for monitoring/supervision of residents in the rotunda. Staff #1 left her post without informing the nurse. Resident #1 fell forward out of their wheelchair while sitting in the rotunda with no supervision. Resident #1 sustained a hematoma with lacerations to the forehead and a cut to the bridge of the nose. Resident #1 was transferred to the hospital for further medical evaluation. Resident #2 who was under the supervision of Staff #2(Certified Nurse Aide) fell out of their wheelchair when the wheelchair rolled backwards while outside getting some fresh air. Facility video footage reviewed by the administrator showed Staff #2 on their cell phone with their back towards the resident unsupervised. Resident #2 sustained a hematoma to the left frontal occipital region of the forehead. In addition, Staff #2 picked Resident #2 up and placed them back in the wheelchair before calling for assistance. Findings include: Resident #1 was admitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Hyperlipidemia and Congestive Heart Failure the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented no Brief Interview for Mental Status (BIMS) score as the resident had severe cognitive impairment. The resident required dependent and substantial/maximal assist for Activities of Daily Living (ADLs). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had severe cognitive impairment. The resident required dependent and substantial/maximal assist for Activities of Daily Living (ADLs). The comprehensive care plan (CCP) initiated 10/25/2023 documented that Resident #1 was high risk for falls related to dementia, muscle weakness, unsteady gait, impaired safety awareness and incontinent of bowel and bladder. Interventions included to anticipate and meet resident's needs, follow fall protocol, and ensure the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. The facility security camera footage was reviewed on 12/12/2023 and Resident #1 is seen siting in their wheelchair in the rotunda with a bed side table in front of them. There were approximately 14 other residents seen on video in the rotunda with the Staff #6(Recreation Therapist) engaged in a BINGO activity. Resident #1 moved their leg and leaned over the bed side table sliding out of the wheelchair and onto the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Accident/Incident Occurrence Report dated 11/16/2023 documented Resident #1 had a fall in rotunda at 2:02 PM and sustained superficial laceration to forehead and nasal bridge, hematoma to forehead, bruising and bleeding to nose. Ice was applied to forehead and nasal bridge, wounds cleaned. Wounds cleaned with normal saline bacitracin applied and covered with dry pressure dressing. Neuro checks initiated immediately until Emergency Medical Service arrived. Physician and Resident #'s1 family notified. An interview was conducted with Staff #1(Certified Nursing Aide) on 12/12/2023 at 12:04 PM and they stated they were assigned rotunda duty on 11/16/2023 from 1:30 PM to 2:00 PM. Rotunda duty is to monitor and supervise the resdients in the rotunda. Staff #1 stated when they started their rotunda duty, the residents were having a BINGO activity and one of the activity staff was in the rotunda calling out the BINGO numbers. Staff #1 stated they were prepping for a colonoscopy the next day and needed to go to the restroom. Staff #1 stated they did not inform anyone they were leaving their post to the restroom. As they were exiting the restroom, they heard someone scream and when they got to the rotunda, Resident #1 was on the floor. Staff #1 stated they had a meeting with the floor nurse and Staff #4(Assistant Director of Nursing) after the incident and was suspended for 2 days. Staff #1 stated they were in serviced on the importance of rotunda duty and communicating when they need to leave their post as well as ensuring they are alert and aware of residents where abouts while on duty. An interview was conducted on 12/12/2023 at 1:15 PM with Staff #6 (Recreation Therapist and they stated they were in the rotunda conducting a BINGO game with the residents when Resident #1 fell . Staff #6 stated they were calling out the numbers and all of a sudden they looked up and Resident #1 was on the floor. Staff #6 stated they went over and grabbed the wheelchair because the chair was on top of the resident. Staff #6 stated the nurse came to assist. They then realized there was no aide in the rotunda. The routine is that there is an aide assigned to the rotunda to monitor/supervise the residents but there was no aide at the time of the incident. An interview was conducted with Staff #4(Assistant Director of Nursing) on 12/12/2023 at 1:37 PM and they stated they were notified of Resident #1's fall in the rotunda by Staff #3 (Registered Nurse). Staff #4 stated during their investigation, Staff # 1 stated they left their post at the rotunda without making other staff members aware. Staff #4 stated the rotunda duty was put in place as a precaution to prevent resident falls. Staff #1 was suspended during the the investigation and retrained on rotunda duty and its significance. Resident #2 was admitted on [DATE] with diagnoses including Chronic Kidney Disease, Essential Hypertension and Heart Failure. The Minimum Data Set (MDS, an assessment tool) dated 10/06/2023, documented that the resident had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 08/15, associated with intact cognition (00-7 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2 Incident/Accident Report dated 05/31/2023 documented, at approximately 2 PM a nurse was called to assist with Resident #2 as the resident had a fall while outside in front of the building. Hematoma observed to left side of forehead. Ice pack applied with first aid rendered. No major injuries noted. Residdent was assessed by physician. Neuro checks ordered and x-rays to head and bilateral hips ordered. Staff #2 assigned to monitor resident reported Resident #2 fell while they were outside in front of the building. Resident #2 stated staff accidently wheeled them onto a rough surface that caused wheelchair to turn and fall. Facility Investigation concluded: based on review of facility camera system (CCTV), staff interview and Resident #2's account of the incident, the fall could have been avoided. Review of Employee Disciplinary Notice dated 05/31/2023 given to Staff #2 stated on 05/31/2023 at approximately 1:50 PM a rapid response was called. Upon responding, Staff #2 was observed with Resident #1 in wheelchair and hematoma noted to left frontal occipital region. Staff #2 was asked what happened in which they stated that the sun blinded them while they were pushing Resident #2 outside and Resident #2 fell . During an interview with Resident #2 they stated they should know there was a curb there and I fell . Upon reviewing the facility camera system (CCTV), it was observed that Staff #2 was on their phone with their back turned to Resident #2. Resident #2 was unsupervised when the wheelchair wheeled backwards, and Resident #2 fell and sustained injury-hematoma. Staff #2 also picked Resident #2 up and placed them back in the wheelchair before calling for assistance. There was a violation of providing safe care and usage of cellular device while providing care. This action indicated gross misconduct and negligence with impaired judgment that has the propensity to harm other residents. Staff #2 was terminated and last day of employment with the facility was 05/31/2023. During an interview on 12/20/2023 at 11:31 AM with Staff #2 they stated they took Resident #2 outside on 05/31/2023 to get some fresh air. Staff #2 stated the lock on Resident #2's wheelchair was broken and Resident #2's chair went off the sidewalk and Resident #2 fell . Staff #2 stated they were assisted by a painter that was working outside the building to pick up the resident and put them back into their wheelchair. Resident #2 had a bruise on the side of their head but kept stating that they were okay. Staff #2 stated they reported the fall to the nurse and the resident was assessed. Staff #2 stated they were called down to department head' office and the facility camera footage was reviewed with them. Staff #2 stated they wrote a statement on what happened and were fired for using their phone. Staff #2 stated they understood why they were fired. Prior to the incident, they were trained on what to do when a reisdent falls but they panic during the incident and moved the resident before they were assessed by a nurse. During an interview on 12/20/2023 at 11:41 AM with Staff #4, they stated the previous Director of Nursing conducted the investigation for Resident #2's fall on 05/31/2023. Staff #4 stated Staff #2 was terminated after the investigation was concluded. Staff are trained on fall prevention and staff must notify a nurse immediately after a fall and not touch/move the resident. During an interview on 12/20/2023 at 12:26 PM with Resident #2, Resident #2 had in both hearing aids but would not respond to surveyor. Resident #2 continued to asked surveyor who they were multiple times but was not responsive to questioning. (continued on next page)

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/2023 at 1:13 PM with Staff #10(Administrator), they stated they were notified by Staff #7(previous director of nursing) of the investigation regarding Resident #2's fall. Staff #10 stated they usually do not fire staff before the conclusion of an investigation but in this case all the department heads came together and reviewed the investigation and agreed to terminate Staff #2. Staff #10 stated the facility videos were not been saved at the time of the incident so they did not have the footage available at the time of the onsite investigation for the surveyor to review. Presently all facility video footages are been stored on a flash drive for review when needed. 10NYRCC 415.12(h)(2)