STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335829	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adira at Riverside Rehabilitation and Nursing	120 Odell Avenue Yonkers, NY 10701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335829	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adira at Riverside Rehabilitation and Nursing	120 Odell Avenue Yonkers, NY 10701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview conducted during the abbreviated survey (2581942), the facility failed to ensure all residents were free of accident hazards and that each resident received assistance to prevent falls for one (1) (Resident #1) of three (3) residents reviewed for accidents. Specifically, Resident #1 sustained a head injury after a fall from their bed on 08/05/2025. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.Findings include: The policy titled 'Fall Prevention Program' issued 03/28/2021 and reviewed 05/30/2025 documented all residents, by virtue of age, illness/injury and placement, are considered to be at risk for falls. A falls risk assessment will be completed on admission and quarterly to identify specific risk and develop an individualized care plan. The policy titled 'Turn and Positioning in Bed: Proper Technique' effective 01/28/2020 and reviewed 05/29/2025 documented the procedure of turning a resident to side lying position. The procedure included gently roll him towards you. (NEVER AWAY). The policy further documented Turning A Resident in Bed, Important points to remember included stand and face the direction of the move to be made, stand close to the object or resident to be moved; keep the load as close to you as possible. Resident #1 was admitted on [DATE] with diagnoses including, but not limited to, cerebrovascular disease (condition that affects blood flow to your brain), chronic respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide), and anemia (low levels of healthy red blood cells). The 11/27/2023 admission Fall Risk Assessment documented Resident #1 was a low risk. The 11/28/2023 Activities of Daily Living care plan documented Resident #1 was dependent for toileting hygiene, dependent for personal hygiene, dependent to roll left and right. The 11/30/2023 Fall/Injury care plan documented Resident #1 had cardiovascular disease, cerebrovascular accident (stroke), and incontinence. Interventions included to anticipate the needs of resident with regards to activities of daily living, rehabilitation referral for evaluation secondary to fall, evaluate the pattern of falls if resident fell more than once and investigate cause of the fall immediately. The 05/04/2024 Certified Nurse Aide Instruction documented one (1) person physical assist for bed mobility. The 06/23/2025 Quarterly Minimum Data Set assessment documented Resident #1 had severe cognitive impairment, required partial/moderate assistance roll left to right, and had no history of falls. The 08/05/2025 Fall Incident Report completed by Nursing Supervisor #1, documented the resident rolled over from the bed and fell to the floor when Certified Nurse Aide #1 turned them to the right side. Resident was found lying on their back with laceration/hematoma (a tear or cut in the skin/bruise) on left side of forehead, bruising on right hand and abrasion on left knee. No changes in level of consciousness, alert and oriented x3 (alert and oriented to person, place and time), no changes in range of motion. Physician and next of kin were notified. The incident report concluded that no abuse, neglect or mistreatment occurred. The 08/05/2025 7:14 AM progress note written by Nursing Supervisor #1 documented Resident #1 was observed lying on their back on the right side of the bed. On assessment, Resident #1 sustained laceration/hematoma on the left side of their forehead. Bleeding noted on the site. Bruising noted on the right hand and abrasion on the left knee. Resident #1 complained of pain on their left forehead. Wheezing noted on auscultation. Blood pressure 162/78, pulse rate 121, respiration rate 20, temperature 97.7, and oxygen saturation 97% at room air. The 08/05/2025 Summary of Investigation completed by Assistant Director of Nursing documented resident was dependent on bed mobility required assist of one (1) when rolling from left to right when in bed. Had a fall, sustained hematoma on left side of forehead and was transferred to the hospital. The investigation documented that as per Certified Nurse Aide #1, they positioned the Resident #1 on the side, rolled the dirty linen underneath the resident and was reaching for clean linen and chux (absorbent pad). While providing the care, the resident rolled unexpectedly, and Resident #1 started to slide off the bed. Certified Nurse Aide #1 tried to grab the resident but could not break the fall. Nursing Supervisor reported resident had laceration/hematoma on the left side of forehead, bleeding noted. Resident was transferred to the hospital. The finding of computed tomography (CT) scan of the head done at the hospital showed diffuse subarachnoid hemorrhage (bleeding into the space between the brain and the membranes that cover it) in the frontal lobe, right parietal lobe and right temporal lobe. Left sided subdural hematoma (a collection of blood between the brain and the dura mater, the tough outer layer of the brains protective covering). The Medical Director reviewed the result of the hospital computed tomography scan, determined that the subarachnoid hemorrhage occurred before the fall and not as a result of the fall. During an interview on 10/10/2025 at 10:59 AM, Medical Director stated that