| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335829 | A. Building<br>B. Wing | 04/14/2026 |

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

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|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during an abbreviated survey, the facility did not ensure services provided by the facility met professional standards of quality for two (Residents #1 and #6) of five residents sampled for pressure ulcer review. Specifically, 1) Wound Care Nurse #2 transcribed treatment orders received from the Wound care Physician for Resident #6 to occur more frequently than recommended 2) Wound Care Nurse #2 made changes to treatment orders for Resident #1 that were not recommended by the wound care specialist.The findings are:1) Resident #6 had diagnoses of chronic respiratory failure with ventilator dependence and cerebral infarction.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #6 was severely cognitively impaired and totally dependent on staff to perform activities of daily living. Resident #6 had three unhealed pressure ulcers present on admission to the facility and one unhealed facility-acquired pressure ulcer.The Nursing Note dated 03/23/2026 documented Resident #6 was readmitted from the hospital after receiving a blood transfusion for anemia and had sacral, right mid-back, right buttock, and left lateral leg pressure ulcers.The Physician Orders transcribed by Registered Nurse #7 dated 03/23/2026 documented Resident #6 was ordered treatment to their right mid-back and right lateral buttock daily and as needed. Resident #6's right medial buttock, sacral, and left lower leg ulcers were ordered treatment twice daily and as needed.The Wound Note dated 03/27/2026 documented Wound Physician Assistant #1 ordered treatments to be administered daily and as needed to Resident #6's right mid-back, sacral, right medial buttock, right lateral buttock and left lateral leg ulcers.Physician Orders transcribed by Wound Nurse #2 dated 03/27/2026 documented treatment orders for Resident #6's mid-back and left lateral leg twice daily and sacral, right medial buttock, and right lateral buttock three times daily. The Treatment Administration Record for 03/2026 documented Resident #6 received treatment to their left lower leg and mid-back twice daily and sacral, right medial buttock, and right lateral buttock three times daily in accordance with Physician Orders from 03/27/2026 until the resident's hospitalization on 04/03/2026. On 03/31/2026 at 11:19 AM and 2:35 PM, Wound Care Nurse #2 was interviewed and stated Resident #6 had wounds to the right inferior mid-back, sacrum, right lateral buttock, middle buttock, and left lateral leg. Resident #6's right buttock wound had purulent discharge and showed signs of infection. Wound Care Nurse #2 stated the wound care specialist verbally recommended treatment orders during weekly wound rounds. Wound Care Nurse #2 stated they transcribed the treatment order recommendations onto the Physician's Orders and updated the resident's care plan. Resident #6 had wounds with excessive drainage, and their treatment orders were twice daily until 03/27/2026 when Wound Care Nurse #2 stated they changed Resident #6's treatment orders to three times daily because they noted the resident still had excessive drainage from their ulcers. Resident #6 has had excessive drainage for at least a week.On 04/03/2026 at 11:34 AM, Wound Physician Assistant #1 was interviewed and stated they did not give recommendations for Resident #6 to receive treatment more than once daily. Resident #6 had pressure ulcers with chronic infections and Wound Physician Assistant #1 stated they would have recommended Resident #6 be hospitalized if they knew the resident required wound care more than once daily for excessive drainage. Wound Physician Assistant #1 stated they assessed Resident #6<br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | today during wound rounds and recommended the resident be hospitalized .2) Resident #1 had diagnoses of chronic respiratory failure with ventilator dependence and hypoxic ischemic encephalopathy.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #1 was severely cognitively impaired, totally dependent on staff to perform activities of daily living and had unhealed facility-acquired stage two and three pressure ulcers.The Wound Note by Wound Physician Assistant #3 dated 12/24/2025 documented a wound order for Silvadene to Resident #1's right buttock ulcer. The Nursing Note written by Wound Nurse #2 dated 12/24/2025 documented Wound Physician Assistant #3 evaluated Resident #1 and changed the right buttock treatment to Santyl ointment.The Physician Order transcribed by Wound Nurse #2 dated 12/24/2025 documented Resident #1's right buttock treatment was changed to Santyl ointment. On 04/13/2026 at 4:06 PM and 04/14/2026 at 10:00 AM, the Assistant Director of Nursing was interviewed and stated they were responsible for overseeing the wound care program and could not recall the last time Wound Care Nurse #2 performed a competency related to wound care. The facility did not have an inservice coordinator and Wound Care Nurse #2 received wound care inservice from the facility's wound care specialist vendor. The Assistant Director of Nursing stated the nurses on the ventilator unit reported that all residents with pressure ulcers required a dressing change more than once daily because every time they soiled their incontinence brief, the resident's dressings became soiled. The Assistant Director of Nursing stated residents should be ordered treatments according to the wound care specialist recommendations and should be provided more than once daily only as needed.10 NYCRR 415.11(c)(3)(i) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the abbreviated survey, the facility did not ensure residents received quality care for two (2) (Residents #1 and #6) of five (5) residents reviewed for pressure ulcers. Specifically, 1) Resident #6 was ordered to receive wound treatment more frequently than recommended by the wound care specialist, 2) wound care specialist findings and recommendations for Resident #1 were not accurately transcribed and signs of worsening infection were not thoroughly reviewed and addressed.The findings are:1) Resident #6 had diagnoses of chronic respiratory failure with ventilator dependence and cerebral infarction.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #6 was severely cognitively impaired and totally dependent on staff to perform activities of daily living. Resident #6 had three unhealed pressure ulcers present on admission to the facility and one unhealed facility-acquired pressure ulcer.The Nursing Note dated 03/23/2026 documented Resident #6 was readmitted from the hospital after receiving a blood transfusion for anemia and had sacral, right mid-back, right buttock, and left lateral leg pressure ulcers.The Physician Orders transcribed by Registered Nurse #7 dated 03/23/2026 documented Resident #6 was ordered treatment to their right mid-back and right lateral buttock daily and as needed. Resident #6's right medial buttock, sacral, and left lower leg ulcers were ordered treatment twice daily and as needed.The Wound Note dated 03/27/2026 documented Wound Physician Assistant #1 ordered treatments be administered daily and as needed to Resident #6's right mid-back, sacral, right medial buttock, right lateral buttock and left lateral leg ulcers.Physician Orders transcribed by Wound Nurse #2 dated 03/27/2026 documented treatment orders for Resident #6's mid-back and left lateral leg twice daily and sacral, right medial buttock, and right lateral buttock three times daily. The Treatment Administration Record for 03/2026 documented Resident #6 received treatment to their left lower leg and mid-back twice daily and sacral, right medial buttock, and right lateral buttock three times daily in accordance with Physician Orders from 03/27/2026 until 04/03/2026. On 03/31/2026 at 11:19 AM and 2:35 PM, Wound Care Nurse #2 was interviewed and stated Resident #6 had wounds to the right inferior mid-back, sacrum, right lateral buttock, middle buttock, and left lateral leg. Resident #6's right buttock wound had purulent discharge and showed signs of infection. Wound Care Nurse #2 stated the wound care specialist verbally recommended treatment orders during weekly wound rounds, and they transcribe the treatment orders and recommendations onto the Physica Orders and updated the resident's care plan. Wound Care Nurse #2 stated Resident #6 had wounds with excessive drainage, and their treatment orders were twice daily last Friday, 03/31/2026, when Wound Care Nurse #2 stated they changed Resident #6's treatment orders to three times daily because they noted the resident still had excessive drainage from their ulcers. Wound Care Nurse #2 stated Resident #6 has had excessive drainage for at least a week.On 04/03/2026 at 11:34 AM, Wound Physician Assistant #1 was interviewed and stated they did not give recommendations for Resident #6 to receive treatment more than once daily. Resident #6 had pressure ulcers with chronic infections and Wound Physician Assistant #1 stated they were not aware Resident #6 had excessive drainage and would have recommended Resident #6 be hospitalized if they knew the resident required wound care more than once daily. Wound Physician Assistant #1 stated they assessed Resident #6 today during wound rounds and recommended the resident be hospitalized .2) Resident #1 had diagnoses of chronic respiratory failure with ventilator dependence and hypoxic ischemic encephalopathy.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #1 was severely cognitively impaired, totally dependent on staff to perform activities of daily living and had unhealed facility-acquired stage two and three pressure ulcers.Resident #1's Lab Results dated 12/05/2025 documented Resident #1 had an elevated white blood cell count at 12.79 cubic microliters with a normal reference range of 3.98 to 10.04 cubic microliters.Resident #1's Lab Results dated 12/08/2025 documented Resident #1's white blood cell count increased to 16.13 cubic<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | microliters.The Nurse Practitioner #1 Note dated 12/09/2025 documented Resident #1 had an elevated white blood cell count and infected right buttock ulcer. The note documented Resident #1 would be ordered Zosyn, an intravenous antibiotic, and the wound care team would follow up. d unhealed facility-acquired stage two and three pressure ulcers.The Physician Order dated 12/09/2025 documented Resident #1 was ordered a urinalysis, urine culture, and intravenous Zosyn every eight hours for seven days.A Nurse Practitioner Note dated 12/13/2025 documented Resident #1 did not have a urinary tract infection according to their urinalysis results from 12/10/2025 and Zosyn was discontinued on day four of seven before being completed. The Wound Note by Wound Physician Assistant #3 dated 12/24/2025 documented a wound order for Silvadene to Resident #1's right buttock ulcer. The Nursing Note written by Wound Nurse #2 dated 12/24/2025 documented Wound Physician Assistant #3 evaluated Resident #1 and changed the right buttock treatment to Santyl ointment.The Physician Order transcribed by Wound Nurse #2 dated 12/24/2025 documented Resident #1's right buttock treatment was changed to Santyl ointment. Lab Results dated 12/24/2025 documented Resident #1's white blood cell count increased to 20.63 cubic microliters.The Nursing Note dated 12/25/2025 documented Resident #1 required a blood transfusion due to low hemoglobin values and was transferred to the hospital. The Hospital Discharge summary dated [DATE] in the resident's electronic medical record documented Resident #1 presented in the emergency room for evaluation of severe anemia. Labs drawn at the hospital on [DATE] documented Resident #1's white blood cell count had increased to over 23.00 cubic microliters. A wound culture from 12/25/2025 reported Resident #1 had klebsiella pneumoniae, proteus mirabilis, Acinetobacter, yeast, and staphylococcus organisms present in their wounds. Resident #1 was ordered and began receiving a treatment course of intravenous antibiotics. The hospital attempted and were unsuccessful in obtaining more information from the facility nursing staff related to Resident #1's change in condition prior to hospitalization.On 04/03/2026 at 12:09 PM, Wound Care Nurse #2 was interviewed and stated they performed treatments daily for all ventilator-dependent residents with pressure ulcers. Wound Care Nurse #2 stated they also made rounds with the wound care specialists every Friday. Wound Care Nurse #2 stated they transcribed the wound care specialist orders by taking exactly what was written in the wound consults under Wound Orders and inputting it into the facility's Physician Orders for the medical doctor to sign off. Wound Care Nurse #2 stated they began to provide ordered treatments to residents on the ventilator unit and any issues related to Resident #1 in December 2025 would have to be deferred to the Nursing Supervisor or the Registered Nurse #4. Wound Care Nurse #2 stated they signed the Treatment Administration Record when providing wound care but does not document any assessment or description of residents' wounds. The Wound care specialist does the assessment and documents the measurements and characteristics.On 04/03/2026 at 1:15 PM, the Director of Nursing was interviewed and stated they did not recall any concerns with Resident #1's hospitalization in 12/2025 and did not receive any reports from the admitting nursing staff that the hospital paperwork documented any concerns such as infected purulent wounds or a moldy feeding tube. The nursing staff are responsible for documenting the characteristics of a resident's wound daily during/after treatment. Any changes in the wound should be referred to the medical doctor.On 04/09/2026 at 11:49 AM, Nurse Practitioner #1 was interviewed and stated they sometimes cover episodic concerns on the ventilator unit. The facility has three nurse practitioners available to address concerns on the ventilator unit and coverage is dependent on who is available. The wound care specialists are responsible for evaluating a resident's wounds, addressing stagnant unhealing wounds, and ordering wound treatments.On 04/10/2026 at 10:23 AM, a telephone interview was conducted with the Pulmonologist who stated they were only responsible for the respiratory care of the ventilator dependent residents. The Pulmonologist stated they were not the primary care physician for any of the residents in the facility and were not responsible for ordering treatments or anything else unrelated to a resident's respiratory condition.10 NYCRR 415.12 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during an abbreviated survey, the facility did not ensure residents with pressure ulcers received treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing in two (Residents #1 and #3) of five residents reviewed for pressure ulcers. Specifically, there was no documented evidence Resident #1's treatment plan was revised to address stagnant wound progress and serosanguinous ulcer drainage for multiple weeks, and 2) Resident #3 was admitted to the facility at risk for skin breakdown and there was no documented evidence they received devices and repositioning to prevent the development of six new pressure injuries.The findings are:The facility policy titled Pressure Ulcer Policy dated 08/30/2024 documented each resident will be assessed for risk factors on admission and for four consecutive weeks. Care plans will be developed with specific interventions based on the resident's risk factors and needs.1) Resident #1 had diagnoses of chronic respiratory failure with ventilator dependence and hypoxic ischemic encephalopathy.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #1 was severely cognitively impaired, totally dependent on staff to perform activities of daily living and had unhealed facility-acquired stage two and three pressure ulcers.The Comprehensive Care Plan related to potential for skin breakdown was created 06/29/2021 and documented Resident #1 had a history of pressure ulcers and impaired mobility. The care plan was revised on 11/15/2024 and documented to provide Resident #1 with preventive skin care, complete a skin risk assessment, assess for skin changes, keep skin clean and dry, and provide incontinent care every two hours.The Physician Order dated 11/06/2025 documented Resident #1 was ordered collagen powder and calcium alginate to treat their stage three sacral and left buttock ulcers. On 12/03/2025, a wound care consult was ordered to evaluate Resident #1's right buttock redness.Wound Care Nurse #2 documented in a Nursing Note dated 12/04/2025 Resident #1's right buttock redness became a stage two pressure ulcer measuring 8cm by 6cm by .1cm with moderate serous drainage.The Wound Note by Wound Physician Assistant #3 dated 12/04/2025 documented Resident #1 had stagnant unhealing stage three sacral and left buttock ulcers. A stage two pressure ulcer with light serous drainage measuring 8cm by 6cm by 1cm located on Resident #1's right buttock and was ordered Silvadene treatment daily.The Physician Orders dated 12/04/2025 documented Silvadene cream was ordered to treat Resident #1's stage two right buttock ulcer.The Nurse Practitioner #1 Note dated 12/09/2025 documented Resident #1 had an infected right buttock ulcer, and the wound care team would follow up.The Wound Note by Wound Physician Assistant #3 dated 12/11/2025 documented Resident #1's wounds remained stagnant, and the left buttock and sacral ulcers were noted with moderate serosanguinous drainage. Santyl ointment was ordered to treat Resident #1's left buttock and sacral ulcers. Silvadene was ordered to treat the right buttock ulcer. The Wound Note by Wound Physician Assistant #3 dated 12/18/2025 documented Resident #1's wounds continued to be stagnant and drained moderate serosanguinous fluid. No changes in measurements, characteristics or treatment orders for Resident #1's sacral, left buttock, and right buttock ulcers.The Wound Note by Wound Physician Assistant #3 dated 12/24/2025 documented Resident #1's wounds continued to be stagnant and drained moderate serosanguinous fluid. There were no changes in measurements, characteristics, or treatment orders for Resident #1's sacral, right buttock, and left buttock ulcers.There was no documented evidence Wound Physician Assistant #3 addressed Resident #1's infected right buttock ulcer or reviewed Resident #1's treatment care plan to address nonhealing pressure ulcers. The Nursing Note dated 12/25/2025 documented Resident #1 was transferred to the hospital for transfusion due to low hemoglobin values.The Certified Nurse Aide Accountability Record for 12/2025 documented Resident #1 laid in the same position in bed for six or more hours 15 days out of the 25 days the resident was in the facility.The Hospital Discharge summary dated [DATE]<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | documented Resident #1 presented in the emergency room for evaluation of severe anemia on 12/25/2025 and their large sacral ulcer was observed to be infected with purulent drainage upon their arrival. A wound culture from 12/25/2025 reported Resident #1 had klebsiella pneumoniae, proteus mirabilis, Acinetobacter, yeast, and staphylococcus organisms present in their wounds. Resident #1 was ordered and began receiving a treatment course of intravenous antibiotics. The sanguinous discharge from Resident #1's sacral ulcer was highly suspicious as the source of Resident #1's infection and anemia.On 04/03/2026 at 12:09 PM, Wound Care Nurse #2 was interviewed and stated they performed treatments daily for all ventilator-dependent residents with pressure ulcers. Wound Care Nurse #2 stated they also made rounds with the wound care specialists every Friday. Wound Care Nurse #2 stated they transcribed the wound care specialist orders by taking exactly what was written in the wound consults under Wound Orders and inputting it into the facility's Physician Orders for the medical doctor to sign off. Wound Care Nurse #2 stated they just provided the ordered treatments to residents on the ventilator unit and any issues related to Resident #1 in December 2025 would have to be deferred to the Nursing Supervisor, Registered Nurse #4. Wound Care Nurse #2 stated they signed the Treatment Administration Reford when providing wound care but do not document any assessment or description of residents' wounds until the wound care specialist has assessed.On 04/03/2026 at 1:15 PM, the Director of Nursing was interviewed and stated they did not recall any concerns with Resident #1's hospitalization in 12/2025 and did not receive any reports from the admitting nursing staff that the hospital paperwork documented any concerns such as infected purulent wounds or a moldy feeding tube. The nursing staff were responsible for documenting the characteristics of a resident's wound daily during treatment administration. Any changes in the wound should be referred to the medical doctor.2) Resident #3 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with vent dependence and cerebral vascular accident.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #3 was severely cognitively impaired, was totally dependent on staff to perform activities of daily living, was at risk for developing pressure ulcer injuries and had one unstageable pressure injury upon admission to the facility. Treatments included a pressure-reducing device for the bed, dressing and ointment application, and turning and repositioning.The Patient Review Instrument dated 07/15/2024 documented Resident #3 had a stage two coccyx pressure ulcer and should be placed on skin and decubitus precautions.The Nursing admission assessment dated [DATE] documented Resident #3 was at high risk for developing pressure ulcers.The Physician admission assessment dated [DATE] documented Resident #3 had an unstageable sacral wound and their treatment plan included assistance with incontinent brief change.Physician Orders dated 07/18/2024 documented orders for Medi-honey daily and as needed and a wound consultation for Resident #3's sacral wound. The Comprehensive Care Plan related to skin breakdown created 07/20/2024 documented interventions to prevent Resident #3 from having skin breakdown included completing a skin risk assessment, providing protective and preventive skin care, monitoring skin during daily care, assessing for changes in skin condition each shift, keeping skin clean and dry, providing incontinent care every two hours, turning and positioning every two hours, elevating legs as needed, and providing appropriate pressure relieving devices as per physical and occupational therapy recommendations.The Physical Therapy Evaluation dated 07/19/2024 documented Resident #3 was awake, able to mouth their name, and able to follow one step commands. Resident #3 had a sacral ulcer and was on fall and safety precautions.There was no documented evidence Resident #3 was evaluated for offloading devices to prevent further skin breakdown.The Wound Note by Wound Physician Assistant #3 dated 7/19/2024 documented Resident #3 had an unstageable sacral ulcer measuring 9cm by 7cm with no depth. Medi-honey treatment was ordered daily and as needed. Physician Assistant #3 documented Resident #3 would have a follow-up wound consultation in one week.Nurse Practitioner #1's Note dated 07/30/2024 documented Resident #3 was evaluated for low blood pressure. Resident #3's skin was dry, bilateral feet had dark skin discoloration, and right lateral skin abrasion was noted. Nurse<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Practitioner #1 documented fall precautions and intravenous fluid hydration to address Resident #3's condition.The Nursing Note dated 07/31/2024 at 6:01 AM documented Registered Nurse #7 received Resident #3 fully awake and responsive to tactile stimuli during perineal care and wound dressing.The Nursing Note dated 07/31/2024 at 10:11 AM documented Registered Nurse #9 was informed that Resident #3 had an abrasion to their left hip with an opening measuring 4cm by 4cm. Resident #3 was also noted with deep tissue injuries to their right and left heel, right and left ankle, and right hip. Staff were using a draw sheet with Resident #3 to reduce friction and shear.Physician Orders dated 07/31/2024 documented Resident #3 was ordered a wound consult for deep tissue injuries observed to their right and left medial heel, right and left ankle, and right hip. Bilateral heel boots were issued to increase comfort, maintain skin integrity, and limit skin breakdown. Skin prep treatment was ordered twice daily to Resident #3's left and right heel, right hip, and right ankle. Zinc oxide treatment was ordered daily for Resident #3's left hip abrasion.The Certified Nurse Aide Accountability Record for 07/2024 was reviewed and there was no documented evidence turning and positioning assistance were provided to Resident #3 in accordance with the resident's plan of care.The Certified Nurse Aide Accountability Record for 08/2024 was reviewed and documented turning and positioning assistance for Resident #3 every two hours starting 08/08/2024.There was no documented evidence Resident #3 was seen by the wound care specialist within a week of their first assessment on 07/19/2024.On 04/09/2026 at 12:49 PM, the Director of Nursing was interviewed and stated they did not recall Resident #3's stay at the facility. If the resident developed pressure ulcers in the facility, a pressure ulcer investigation would be conducted to determine how the pressure ulcers occurred and what further intervention needed to prevent further skin breakdown. The Director of Nursing stated they would not necessarily do an investigation into an abrasion, which is caused by force and not related to pressure ulcers.On 04/13/2026 at 12:00 PM, Certified Nurse Aide #8 was interviewed via telephone and stated they were assigned to the ventilator unit and actively looked at their assigned resident's skin every time they changed a resident's brief. Turning and repositioning assistance was provided to those residents who triggered for it on their accountability records. Not all residents required assistance with turning and repositioning. Certified Nurse Aide #8 stated they signed the Accountability Record every time they assisted with a task. They informed the licensed nurses if they observe any change sin condition with their assigned residents. Certified Nurse Aide #8 stated they did not have anywhere to document when they observed changes and were dependent on whether the licensed nurses appropriately pursued their reported concerns. The physical and occupational therapists were responsible for bringing offloading and other cushioning devices to the units and in servicing the direct care staff on how to use them with the residents.On 04/13/2026 at 3:12 PM, Registered Nurse #7 was interviewed via telephone and stated they did not recall Resident #3 specifically, Registered Nurse #7 stated they performed skin assessments of all their residents every shift and especially checked their back and bony prominences. Registered Nurse #7 stated they don't know how Resident #3 was able to develop multiple deep tissue injuries on their ankles and heels within a few hours of providing wound care to the resident. Registered Nurse #7 stated they were not aware of any facility investigation conducted to determine how Resident #7 developed these pressure-related injuries and hip abrasion.On 04/13/2026 at 4:06 PM and 04/14/2026 at 10:00 AM, the Assistant Director of Nursing was interviewed via telephone and stated they performed an investigation into Resident #3's facility-acquired deep tissue injuries in 08/2024 and determined that Resident #3's skin issues were unavoidable. The Assistant Director of Nursing stated they were responsible for overseeing the wound care program and could not recall the last time Wound Care Nurse #2 performed a competency related to wound care. The facility did not have an inservice coordinator and Wound Care Nurse #2 received wound care inservice from the facility's wound care specialist vendor.On 04/09/2026 at 11:49 AM, Nurse Practitioner #1 was interviewed and stated they sometimes covered episodic concerns on the ventilator unit. The facility had three nurse practitioners available to address concerns on the ventilator unit and coverage was dependent on who was<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335829 | A. Building<br>B. Wing | 04/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Adira at Riverside Rehabilitation and Nursing | 120 Odell Avenue<br>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.

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | available. The wound care specialists were responsible for evaluating a resident's wounds, addressing stagnant unhealing wounds, and ordering wound treatments.On 04/10/2026 at 10:23 AM, a telephone interview was conducted with the Pulmonologist who stated they were only responsible for the respiratory care of the ventilator dependent residents. The Pulmonologist stated they were not the primary care physician for any of the residents in the facility and were not responsible for ordering treatments or anything else unrelated to a resident's respiratory condition.10 NYCRR 415.12(c)(2) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during an abbreviated survey, the facility did not ensure the physician reviewed the resident's total program of care, including medications and treatments, at each visit for two (Residents #6 and #1) of four ventilator-dependent residents sampled. Specifically, 1) discrepancies in the wound specialist's and the attending physician's ordered treatments were not addressed during physician visits, and 2) there was no evidence the attending physician reviewed labs reporting increasingly abnormal values and wound notes reporting stagnant, unhealing wounds with ongoing drainage.The findings are:1) Resident #6 had diagnoses of chronic respiratory failure with ventilator dependence and cerebral infarction.Resident #6's facesheet documented the Pulmonologist was the resident's Attending Physician.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #6 was severely cognitively impaired and totally dependent on staff to perform activities of daily living. Resident #6 had three unhealed pressure ulcers present on admission to the facility and one unhealed facility-acquired pressure ulcer.The Wound Note dated 03/27/2026 documented treatments be administered daily and as needed to Resident #6's right mid-back, sacral, right medial buttock, right lateral buttock and left lateral leg ulcers.Physician Orders signed by the Pulmonologist dated 03/27/2026 documented treatment orders for Resident #6's mid-back and left lateral leg twice daily and sacral, right medial buttock, and right lateral buttock three times daily. The Treatment Administration Record for 03/2026 documented Resident #6 received treatment to their left lower leg and mid-back twice daily and sacral, right medial buttock, and right lateral buttock three times daily in accordance with Physician Orders on 03/27/2026. There was no documented evidence Resident #1's attending physician, the Pulmonologist, reviewed and addressed treatment orders recommended by the wound care specialist. Subsequent medical notes did not include an evaluation or address recommended treatments from the wound care team. On 03/31/2026 at 11:19 AM and 2:35 PM, Wound Care Nurse #2 was interviewed and stated Resident #6 had wounds to the right inferior mid-back, sacrum, right lateral buttock, middle buttock, and left lateral leg. Resident #6's right buttock wound had purulent discharge and showed signs of infection. Wound Care Nurse #2 stated the wound care specialist verbally recommended treatment orders during weekly wound rounds. Wound Care Nurse #2 stated they transcribed the treatment order recommendations onto the Physica Orders and update the resident's care plan. Resident #6 had wounds with excessive drainage, and their treatment orders were twice daily until last Friday when Wound Care Nurse #2 stated they changed Resident #6's treatment orders to three times daily because they noted the resident still had excessive drainage from their ulcers. Resident #6 has had excessive drainage for at least a week.On 04/03/2026 at 11:34 AM, Wound Physician Assistant #1 was interviewed and stated they did not give recommendations for Resident #6 to receive treatment more than once daily. Resident #6 had pressure ulcers with chronic infections and Wound Physician Assistant #1 stated they would have recommended Resident #6 be hospitalized if they knew the resident required wound care more than once daily for excessive drainage. Wound Physician Assistant #1 stated they assessed Resident #6 today during wound rounds and recommended the resident be hospitalized .2) Resident #1 had diagnoses of chronic respiratory failure with ventilator dependence and hypoxic ischemic encephalopathy.Resident #1's facesheet documented the Pulmonologist was the resident's attending physician.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #1 was severely cognitively impaired, totally dependent on staff to perform activities of daily living and had unhealed facility-acquired stage two and three pressure ulcers.The Physician Order prescribed by the Pulmonologist dated 11/06/2025 documented Resident #1 was ordered collagen powder and calcium alginate to treat their stage three sacral and left buttock ulcers. On 12/03/2025, a wound care consult was ordered to evaluate<br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #1's right buttock redness.The Wound Note dated 12/04/2025 documented Resident #1 had stagnant unhealing stage three sacral and left buttock ulcers. Resident #1 was ordered to continue their current wound treatments. Lab Results dated 12/05/2025 documented Resident #1 had an elevated white blood cell count at 12.79 cubic microliters with a normal reference range of 3.98 to 10.04 cubic microliters. The hemoglobin was low at 7.1g/dL with a reference range of 11.2 to 15-7. The hematocrit was low at 24.4% with a reference range of 34.1 to 44-9%.Lab Results dated 12/08/2025 documented Resident #1's white blood cell count increased to 16.13 cubic microliters. The hemoglobin was 7.0g/dL and hematocrit was 24.2%.Nurse Practitioner #1's Note dated 12/09/2025 documented Resident #1 had an elevated white blood cell count and infected right buttock ulcer. The note documented Resident #1 would be ordered Zosyn, an intravenous antibiotic, and the wound care team would follow up.The Physician Order signed by Nurse Practitioner #3 dated 12/09/2025 documented Resident #1 was ordered a urinalysis, urine culture, and intravenous Zosyn every eight hours for seven days.The Wound Note dated 12/11/2025 documented Resident #1's wounds remained stagnant, and the left buttock and sacral ulcers were noted with moderate serosanguinous drainage. Santyl ointment was ordered to treat Resident #1's left buttock and sacral ulcers. Silvadene was ordered to treat the right buttock ulcer. Nurse Practitioner #3's Note dated 12/13/2025 documented Resident #1 did not have a urinary tract infection according to their urinalysis results from 12/10/2025 and Zosyn was discontinued on day four of seven before being completed. There was no documented evidence Resident #1's attending physician, the Pulmonologist, reviewed and addressed the resident's increasingly abnormal lab values for hemoglobin, hematocrit, and white blood cell counts.The Wound Note dated 12/18/2025 documented Resident #1's wounds continued to be stagnant and drained moderate serosanguinous fluid. There were no changes in measurements, characteristics or treatment orders for Resident #1's sacral, left buttock, and right buttock ulcers.The Monthly Progress Note by the Pulmonologist dated 12/19/2025 documented Resident #1 had pressure ulcers and did not document reference to their unhealing status or recent lab results.The Wound Note dated 12/24/2025 documented Resident #1's wounds continued to be stagnant and drained moderate serosanguinous fluid. There were no changes in measurements, characteristics, or treatment orders for Resident #1's sacral, right buttock, and left buttock ulcers.Lab Results dated 12/24/2025 documented Resident #1's white blood cell count increased to 20.63 cubic microliters.The Nursing Note dated 12/25/2025 documented Resident #1 required a blood transfusion due to low hemoglobin values and was transferred to the hospital.There was no documented evidence the Pulmonologist reviewed and addressed ongoing reports of Resident #1's stagnant, draining, and unhealing pressure ulcers.The Patient Review Instrument dated 12/29/2025 documented Resident #1 had a primary diagnosis of infected stage four decubitus ulcer.The Hospital Discharge summary dated [DATE] documented Resident #1 presented in the emergency room for evaluation of severe anemia on 12/25/2025 and their large sacral ulcer was observed to be infected with purulent drainage upon their arrival. Labs drawn at the hospital on [DATE] documented Resident #1's white blood cell count had increased to over 23.00 cubic microliters. The hospital attempted and were unsuccessful in obtaining more information from the facility nursing staff related to Resident #1's change in condition prior to hospitalization.On 04/03/2026 at 1:15 PM, the Director of Nursing was interviewed and stated they did not recall any concerns with Resident #1's hospitalization in 12/2025 and did not receive any reports from the admitting nursing staff that the hospital paperwork documented any concerns such as infected purulent wounds or a moldy feeding tube. The nursing staff were responsible for documenting the characteristics of a resident's wound daily during treatment administration. Any changes in the wound should be referred to the medical doctor.On 04/09/2026 at 11:49 AM, Nurse Practitioner #1 was interviewed and stated they sometimes covered episodic concerns on the ventilator unit. The facility had three nurse practitioners available to address concerns on the ventilator unit and coverage was dependent on who was available. The wound care specialists were responsible for evaluating a resident's wounds, addressing stagnant<br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | unhealing wounds, and ordering wound treatemnts.On 04/09/2026 at 3:54 PM, the Medical Director was interviewed via telephone and stated the Pulmonologist was assigned as attending physician for the ventilator dependent residents in the facility. The Medical Director stated they were assigned as primary care physician to other residents in the facility and assisted with coverage of the ventilator unit when the Pulmonologist was not available. Questions related to the care of residents on the ventilator unit should be directed to the Pulmonologist. The Medical Director stated the facility's clinicians, including the Medical Director and the Pulmonologist, were responsible for ensuring the wound care specialists were addressing the resident's care plan that orders were carried out. On 04/10/2026 at 10:23 AM, a telephone interview was conducted with the Pulmonologist who stated they were only responsible for the respiratory care of the ventilator dependent residents. The Pulmonologist stated they were not the attending physician for any of the residents in the facility and were not responsible for ordering treatments or anything else unrelated to a resident's respiratory condition.On 04/14/2026 at 11:09 AM, the Administrator was interviewed and stated the Pulmonologist was not the attending physician for the facility's ventilator dependent residents and they did not know anything about the Pulmonologist's designation on Resident #1's and Resident #6's facesheets as their attending physician. The Administrator stated the Medical Director, and the nurse practitioners were responsible for working together to cover the ventilator unit and address resident clinical needs.10 NYCRR 415.15(b)(2)(iii) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during an abbreviated survey, the facility did not ensure infection prevention and control standards were maintained during wound care to prevent the spread of infection to other wounds for 1 (Resident #6) of 2 residents observed for wound care. Specifically, Resident #6's uncovered back and buttock wounds were observed having direct contact with a towel soaked with purulent drainage from soiled dressings removed from the resident's infected right buttock ulcer. The findings are:Resident #6 had diagnoses of chronic respiratory failure with ventilator dependence and cerebral infarction.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #6 was severely cognitively impaired and totally dependent on staff to perform activities of daily living. Resident #6 had three unhealed pressure ulcers present on admission to the facility and one unhealed facility-acquired pressure ulcer.Physician Orders transcribed dated 03/23/2026 documented Resident #6 was on contact precautions for an infection in their right buttock wound. Physician Orders dated 03/27/2026 documented treatment orders for Resident #6 to receive mupirocin 2% topical ointment and calcium alginate packing to their right and medial buttock, Thera-honey gel to the sacrum and right mid-back, and Medi-honey with hydrogel to their left lateral leg. On 03/31/2026 at 11:19 AM and 2:35 PM, Wound Care Nurse #2 was interviewed and stated Resident #6's right buttock wound had purulent discharge and showed signs of infection. Infection control was important to prevent the resident's other wounds from becoming infected.On 03/31/2026 at 11:43 AM, during wound care observation of Resident #6, Resident #6 was observed positioned onto their left side and off their back with Certified Nurse Aide #3 holding onto the resident's right side, while Wound Care Nurse #2 removed three dressings from the resident's right lateral and medial buttock, mid-back and sacrum. Wound Care Nurse #2 did not place a barrier between the resident and the towel soiled from the old dressing. Wound Care Nurse #2 stepped away from Resident #6 to change their gloves and obtain more treatment supplies, Certified Nurse Aide #3 dropped Resident #6 slightly onto their back, allowing the resident's sacral and buttock wounds to touch the towel soaked in multiple spots with dark red drainage. There was no barrier placed between Resident #6's wounds and the towel.On 03/31/2026 at 2:35 PM, Wound Care Nurse #2 was interviewed and stated Resident #6's bed should have had a drop cloth barrier in between the resident and the sheets they were laying on to prevent infection and/or cross-contamination from other infected wounds to wounds without infection. Wound Care Nurse #2 stated they forgot to place a drop cloth on the bed under Resident #6 before the dressing change.On 04/14/2026 at 10:00 AM, the Assistant Director of Nursing was interviewed via telephone and stated besides Wound care Nurse #2, they were also in charge of infection control but have not observed Wound Care Nurse #2's treatment practices. Residents should always be provided with drop cloth barriers to prevent their open wounds from coming into contact with potentially soiled objects. 10 NYCRR 415.19 (b)(4) |