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	08/30/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 44673 Based on record reviews and interviews during the recertification and abbreviated survey (NY00325832) from 8/26/24 to 8/30/24 , the facility did not ensure that a resident's representative was promptly notified of a change in ins status For 1 of 28 residents (Resident #38) reviewed for notification of change. Specifically, Resident #38's designated representative was not made aware the resident had pneumonia and antibiotic was initiated. The findings are: Resident #38 had diagnoses including pneumonia, chronic respiratory failure and dementia. The 8/2/23 Quarterly Minimum Data Set (resident assessment tool) documented the resident had severely impaired cognition and was dependent on staff for all activities of daily living. The 2/25/22 Policy and Procedure titled Notification of Change documented the facility will promptly inform the resident representative when there is a change of condition requiring notification. The 10/8/23 chest x-ray results documents left basilar lung infiltrate (pneumonia). The 10/8/23 physician order documented Cefuroxime (antibiotic) one tablet by gastrostomy tube twice a day for 7 days for pneumonia. Review of the resident's record revealed there was no documented evidence the resident's representative was notified the resident had pneumonia and an antibiotic was initiated. During an interview on 8/30/24 at 10:50 AM, the Director of Nursing stated the nurses were responsible for family notification and it was their expectation that the family would be notified promptly with any changes. During an interview on 8/30/24 at 11:00 AM with Registered Nurse #10 stated they did not remember the incident. The resident's family was very involved and they usually updated them on any changes in the resident's physical condition. Registered Nurse #10 also stated it was the facility's policy to update the family with all changes especially since the resident had a diagnosis of Dementia. 415.3(f)(2)(ii)(b)

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: 335829	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Adira at Riverside Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Odell Avenue 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 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. 50766 Based on observations record review and interviews, during the recertification survey from 8/25/24 to 8/30/24, the facility did not ensure that the Comprehensive Care Plans were reviewed and revised in a timely manner to reflect the resident's changing needs and current status as evidenced by 1 of 4 residents (Resident #24) reviewed for skin impairments. Specifically, Resident #24 acquired a pressure injury on the left heel and the care plan was not updated with goals and interventions to promote wound healing. The findings are: Resident #24 had diagnoses including type 2 diabetes, Alzheimer's disease, and a history of pressure injuries. The Quarterly Minimum Data Set (an assessment tool) dated 7/15/2024 documented Resident # 24 had severe cognitive impairment, was dependent on staff for chair/bed-to-chair transfers and required substantial to maximal assistance for bed mobility and sitting on the side of the bed. Resident #24 was frequently incontinent of bowel and bladder, was at risk for pressure ulcers, had no pressure ulcers/other skin problems (ulcers, wounds), had a pressure reducing device for chair/bed, was on a turning/repositioning program, received nutrition or hydration intervention to manage skin problems, and received ointments/medications other than to feet. The 8/19/2024 Skin Integrity Care Plan documented Resident #24 was at risk for skin breakdown or pressure ulcer injury. The goal was to have no skin breakdown for 90 days. Interventions included turn and position every 2 hours / as needed, monitor skin during daily care, assess for changes in skin condition each shift, and provide incontinent care every 2 hours and as needed. On 8/26/2024 a wound consult secondary to redness of left heel was added to the care plan. The 8/24/2024 Braden Scale (an assessment used to predict a resident's risk of developing pressure sores/ulcers) documented a score of 11 which indicated that resident was at high risk. The 8/24/2024 at 3:18 PM Nurse Practitioner note documented left heel skin changes. Came to resident secondary to family informing the left heel had skin changes. Skin on left heel had redness with some bleeding. Changes in left heel skin integrity, wound consultation. Start zinc oxide. The 8/24/2024 at 3:50 PM Nursing Progress note documented resident in bed, awake, calm not in any distress. Noted with redness on their left heel, seen by Nurse Practitioner with treatment advised, cleansed with normal saline, applied zinc oxide and covered with foam dressing as ordered. Out of bed at lunch time. Plan of care to continue. There was no documented evidence Resident #24's care plans were updated to include interventions for the left heel redness and to prevent the further deterioration of left heel skin integrity. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 08/27/2024 at 9:34 AM Resident #24 was sleeping on their back in a geriatric chair with their heels resting directly on the geriatric chair footrest. The heels were not off-loaded or elevated. During observation on 08/27/2024 at 11:42 AM Resident #24 was resting on their back in a geriatric chair with their ankles crossed and their heels resting directly on the geriatric chair footrest. Heels were not off-loaded and Resident #24 had socks and slippers on. During a continuous observation on 08/28/2024 from 8:50 AM to 11:41 AM Resident #24 was resting on their back with their ankles crossed and heels resting on the footrest. Resident #24 had socks and slippers on and was not turned/repositioned during this time. During an interview on 08/28/2024 at 1:20 PM Resident #24's family member stated they noticed left heel redness during a visit last week and requested staff to look at the heel. The family member was not aware of any interventions put in place except a request for wound consult to take place Friday, August 30, 2024. During observation on 08/29/2024 at 8:35 AM Resident #24 was resting in bed on their back and their heels were not off-loaded. During observation and interview with Registered Nurse #26 on 08/29/2024 at 9:55 AM, Resident # 24's heels were resting on an air mattress and not off-loaded. The left heel was observed with a soiled, white gauze dressing which was removed by Registered Nurse #26. During an immediate interview, Registered Nurse #26 stated it was an unstageable wound and they were not aware why the wound was dressed in white gauze, not in foam dressing as ordered or why heels were not off-loaded. Registered Nurse #26 did not have an explanation when asked what interventions were implemented to prevent further decline of the heel after report of heel redness on 8/24/2024. During observation and interview on 08/29/2024 at 11:59 AM Nurse Practitioner #27 stated the left heel wound was unstageable and had progressed from heel redness which was reported 8/24/2024. Nurse Practitioner #27 stated nurse judgement should have been applied and heel off-loading, turning and repositioning and heel boots should have been added to the care plan immediately upon report of heel redness. During interview and observation on 08/30/2024 at 9:15 AM Wound Consultant Nurse Practitioner stated the left heel wound was unstageable. They stated pressure ulcer preventative measures could have been put in place when redness was reported on 8/24/2024 including skin prep, heel booties, off-loading, elevating feet, turning and repositioning every two hours. The staff could have taken a picture and sent it to them, and they could have made a referral to physical therapy and occupational therapy to address the resident crossing their legs and for assistive devices. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/30/2024 at 12:03 PM the Director of Nursing stated when a change in skin integrity is reported, the resident should be assessed by the unit registered nurse and an assessment requested from the facility nurse practitioner. Once registered nurse assessment is completed, registered nurse should enter care plans, document notes, notify family of changes and plan of care. Director of Nursing stated interventions should be started immediately based on nursing judgement and orders. Interventions include off-loading, turning and repositioning, resident taken out of bed for period of time, personal hygiene, nutrition review for supplements, supportive devices including cushions, heel boots, hand rolls and possibly, x-rays. Labs including albumin should be ordered. Director of Nursing stated residents at risk for pressure ulcers should be assessed for devices such as chair cushions, heel booties and hand rolls. During interview on 08/30/2024 at 1:30 PM the Medical Director stated the expectation for residents who were at risk for pressure ulcers, included off-loading to begin immediately, turning and repositioning every two hours, efforts to minimize skin excoriation by changing residents frequently, booties used if applicable, and skin barrier ointment. 10 NYCRR 415.11(c)(1)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50766 Based on interview, observation and record review during a Recertification Survey conducted from 8/26/2024 through 8/30/2024, the facility failed to ensure that a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and to prevent the development of pressure ulcers unless the individual's clinical condition demonstrates they were unavoidable. This was evident for 1 of 4 residents reviewed for pressure ulcers (Resident #24). Specifically, Resident #24 was assessed as high risk for pressure ulcers and was identified to have left heel redness on 08/24/2024. The resident's care plan and interventions were not promptly updated and implemented to prevent further deterioration of the left heel skin integrity. Subsequently, on 8/29/2024, the resident's left heel was observed and assessed by the facility nurse practitioner and diagnosed to be an unstageable decubitus (damage to a person's skin caused by constant pressure on an area for a long-time) ulcer. This resulted in actual harm to Resident #24 that is not Immediate Jeopardy. The findings are: The facility's policy titled Pressure Ulcers: Prevention and Care of (dated 5/2001, revised 6/2012) documented it is the policy of the facility to maintain the skin integrity of residents with intact skin and to restore the skin integrity of those residents with pressure ulcers. Actions include: may refer to the Pressure Ulcer Protocol, initiate the resident's care plan with nursing interventions for treatment and prevention of the pressure ulcer, review and update care plan accordingly, may convene a care planning team meeting including the dietician, rehabilitation therapist, physician or nurse/wound care team to develop the interdisciplinary steps required for healing the ulcer, update the interdisciplinary team to reflect the physicians orders and any other interventions decided upon. Supervise care rendered by Certified Nursing Assistant (CNA) to assure optimal positioning (including use of devices) and incontinence care. The undated facility policy for Turning and Positioning a Resident documented turning and positioning of resident in bed is performed as specified in the resident plan of care. The following residents are to be considered for a specified turning and positioning schedule: residents identified as high risk for pressure ulcer development, residents with actual skin ulcer, and residents with limited bed mobility. The Facility Pressure Ulcer Protocol for Care for Stage 1 pressure ulcer guidelines identifies a Stage 1 ulcer definition as intact skin with redness (in darker skin may appear as red/blue or purple hues) of a localized area which is usually over a bony prominence). Please note not all reddened areas are stage 1 pressure ulcers. Some reddened areas are due to moisture associated with skin damage. Guidelines for Interventions include: complete full body assessment on admission, hospital return, during bed bath, shower, incontinent care or anytime when red area is noted, skin assessment to be completed by registered nurse on admission, quarterly and for significant change. May update plan of care with turn and repositioning task. Turn and position for relief of pressure, if applicable. Reduce shear and friction, lubricate skin, inform physician and dietician, provide resident/family/staff education and document on the resident/family care plan, documentation in medical record on staging, location, and treatment, update comprehensive care plan/minimum data set as necessary. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #24 had diagnoses including type 2 diabetes, Alzheimer's disease, and a history of pressure injuries. The Quarterly Minimum Data Set (an assessment tool) dated 7/15/2024 documented Resident # 24 had severe cognitive impairment, was dependent on staff for chair/bed-to-chair transfers and required substantial to maximal assistance for bed mobility and sitting on the side of the bed. Resident #24 was frequently incontinent of bowel and bladder, was at risk for pressure ulcers, had no pressure ulcers/other skin problems (ulcers, wounds), had a pressure reducing device for chair/bed, was on a turning/repositioning program, received nutrition or hydration intervention to manage skin problems, and received ointments/medications other than to feet. The 8/19/2024 Skin Integrity Care Plan documented Resident #24 was at risk for skin breakdown or pressure ulcer injury. The goal was to have no skin breakdown for 90 days. Interventions included turn and position every 2 hours / as needed, monitor skin during daily care, assess for changes in skin condition each shift, and provide incontinent care every 2 hours and as needed. On 8/26/2024 a wound consult secondary to redness of left heel was added to the care plan. The 8/24/2024 Braden Scale (an assessment used to predict a resident's risk of developing pressure sores/ulcers) documented a score of 11 which indicated that resident was at high risk. The risk factors documented sensory perception: very limited. Moisture: very moist. Activity: chairfast. Mobility: very limited. Nutrition: probably inadequate. Friction and shear: problem. There was no documented evidence Resident #24's care plans were updated to include interventions for the left heel redness and to prevent the further deterioration of left heel skin integrity. The 8/24/2024 Care Plan Activity Report for care area: pressure ulcer/injury/skin integrity potential for skin breakdown note documented: It was reported to the writer that the resident had left heel redness, seen, and examined by nurse practitioner, order zinc ointment to be applied to affected area after cleansing with normal saline then cover with foam dressing every shift and as needed. Wife made aware personally. All needs being attended and anticipated. Morning care done, assisted from bed to geriatric chair (large padded reclining chair with wheeled base for people with limited mobility). Kept clean and dry. Continue plan of care. Currently monitored. The Certified Nursing Assistant Documentation History Detail report documented skin checks were performed each shift (3 times a day) by staff from 8/24/2024 through 8/28/2024. The 8/24/2024 at 3:18 PM Nurse Practitioner note documented left heel skin changes. Came to resident secondary to family informing the left heel had skin changes. Skin on left heel had redness with some bleeding. Changes in left heel skin integrity, wound consultation. Start zinc oxide. The 8/24/2024 at 3:50 PM Nursing Progress note documented resident in bed, awake, calm not in any distress. Noted with redness on their left heel, seen by Nurse Practitioner with treatment advised, cleansed with normal saline, applied zinc oxide and covered with foam dressing as ordered. Out of bed at lunch time. Plan of care to continue. There was no documented evidence of further interventions, or progress notes until 8/29/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The August Treatment Administration Record documented Resident #24 received treatment each shift (7 AM- 3 PM, 3 PM-11 PM, 11 PM-7 AM) of topical zinc oxide 20%, apply by topical route every shift to left heel after cleansing with normal saline, then cover with foam dressing from 8/24/2024 through 8/28/2024. The Certified Nurse Aide Documentation Record dated August 2024 documented the resident was turned and positioned every 2 hours from 8:00 PM to 8:00 AM. There was no documented evidence the resident was turned and positioned between 8:00 AM and 8:00 PM. The 8/26/2024 at 3:06 PM Interim Physician Order signed by the Medical Director on 8/27/2024 at 9:54 AM documented wound consult for left heel redness. During observation on 08/27/2024 at 9:34 AM Resident #24 was sleeping on their back in a geriatric chair with their heels resting directly on the geriatric chair footrest. The heels were not off-loaded or elevated. During observation on 08/27/2024 at 11:42 AM Resident #24 was resting on their back in a geriatric chair with their ankles crossed and their heels resting directly on the geriatric chair footrest. Heels were not off-loaded and Resident #24 had socks and slippers on. During a continuous observation on 08/28/2024 from 8:50 AM to 11:41 AM Resident #24 was resting on their back with their ankles crossed and heels resting on the footrest. Resident #24 had socks and slippers on and was not turned/repositioned during this time. During an interview on 08/28/2024 at 1:20 PM Resident #24's family member stated they noticed left heel redness during a visit last week and requested staff to look at the heel. The family member was not aware of any interventions put in place except a request for wound consult to take place Friday, August 30, 2024. During observation on 08/29/2024 at 8:35 AM Resident #24 was resting in bed on their back and their heels were not off-loaded. During observation and interview with Registered Nurse #26 on 08/29/2024 at 9:55 AM, Resident # 24's heels were resting on an air mattress and not off-loaded. The left heel was observed with a soiled, white gauze dressing which was removed by Registered Nurse #26. During an immediate interview, Registered Nurse #26 stated it was an unstageable wound and they were not aware why the wound was dressed in white gauze, not in foam dressing as ordered or why heels were not off-loaded. Registered Nurse #26 did not have an explanation when asked what interventions were implemented to prevent further decline of the heel after report of heel redness on 8/24/2024. Further review of the August 2024 Treatment Administration Record revealed Registered Nurse #26 signed for the heel dressing treatment for the 7:00 AM to 3:00 PM shift on 8/25/2024, 8/26/2024, 8/27/2024, and 8/28/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 08/29/2024 at 10:00 AM, Registered Nurse Supervisor #1 was asked to observe the left heel wound with Registered Nurse #26. During an immediate interview Registered Nurse Supervisor #1 stated, the wound was not stageable and there were areas of necrosis (dead tissue) present. Registered Nurse Supervisor #1 stated they did not know why Resident #24's heels were not off-loaded and was unaware of interventions put in place when redness of the left heel was identified on 8/24/2024. They did not know why the wound was covered with gauze and did not have a foam dressing present as ordered. During observation and interview on 08/29/2024 at 11:59 AM Nurse Practitioner #27 stated the left heel wound was unstageable and had progressed from heel redness which was reported 8/24/2024. Nurse Practitioner #27 stated nurse judgement should have been applied and heel off-loading, turning and repositioning and heel boots should have been added to the care plan immediately upon report of heel redness. During an interview on 08/29/2024 at 1:21 PM, Certified Nursing Assistant #28 stated they report all changes in resident status to the floor registered nurse or Unit Supervisor. Certified Nursing Assistant #28 stated they had not noticed any changes in Resident #24's skin during care since Sunday, August 25, 2024, and Resident #24 was not discussed during reports over the last week. Certified Nursing Assistant #28 stated the resident's family member asked them to check resident's left heel about 4-5 days ago and they informed family member they would provide information to floor registered nurse to assess. Certified Nursing Assistant #28 stated they informed the floor registered nurse of the family member request to assess the left heel. Certified Nursing Assistant #28 stated they were not aware of any interventions put in place for the residents left heel. During an interview on 08/29/2024 at 1:33 PM Registered Nurse #26, stated skin assessments were only completed if there is a change reported and during wound care. Registered Nurse #26 stated they are familiar with Resident #24 and the resident has a wound on the left heel. Registered Nurse #26 stated offloading and repositioning are techniques used to prevent pressure ulcers and they did not routinely off-load the resident's heels except for once on 8/28/2024 when they returned the resident to bed in the evening. Registered Nurse #26 stated the resident is repositioned at mealtimes when in the day room and was not able to provide an answer why the resident was not repositioned every two hours while in the day room or why their heels were not off-loaded while the resident was in the geriatric chair. Registered Nurse #26 stated they should have delegated the task. The 8/29/2024 Nursing progress noted documented the resident was seen and examined by the nurse practitioner with the family at the bedside for a left heel diabetic unstageable ulcer. The nurse practitioner ordered to start Santyl 250 topic ointment to the affected area once daily for 30 days to left heel wound after cleansing with normal saline then cover with foam dressing. To off load bilateral heels with pillows every shift while on bed, to continue to reposition every 2 hours and as needed. Also ordered chest and heel x-ray and lab work. Needs attended to and kept monitored. During interview and observation on 08/30/2024 at 9:15 AM Wound Consultant Nurse Practitioner stated the left heel wound was unstageable. They stated pressure ulcer preventative measures could have been put in place when redness was reported on 8/24/2024 including skin prep, heel booties, off-loading, elevating feet, turning and repositioning every two hours. The staff could have taken a picture and sent it to them, and they could have made a referral to physical therapy and occupational therapy to address the resident crossing their legs and for assistive devices. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During interview on 8/30/2024 at 12:03 PM the Director of Nursing stated when a change in skin integrity is reported, the resident should be assessed by the unit registered nurse and an assessment requested from the facility nurse practitioner. Once registered nurse assessment is completed, registered nurse should enter care plans, document notes, notify family of changes and plan of care. Director of Nursing stated interventions should be started immediately based on nursing judgement and orders. Interventions include off-loading, turning and repositioning, resident taken out of bed for period of time, personal hygiene, nutrition review for supplements, supportive devices including cushions, heel boots, hand rolls and possibly, x-rays. Labs including albumin should be ordered. Director of Nursing stated residents at risk for pressure ulcers should be assessed for devices such as chair cushions, heel booties and hand rolls. During interview on 08/30/2024 at 1:30 PM the Medical Director stated the expectation for residents who were at risk for pressure ulcers, included off-loading to begin immediately, turning and repositioning every two hours, efforts to minimize skin excoriation by changing residents frequently, booties used if applicable, and skin barrier ointment. 10 NYCRR 415.12(c)(1)

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 44673 Based on observation, record review and staff interviews during the recertification survey from 8/26/24-8/30/24, the facility did not ensure that needed services, care and equipment were provided to assure that residents with limited range of motion and mobility maintained or improved function based on the resident's clinical condition for 3 of 3 residents (Residents # 24, #54 and #91) reviewed for position and mobility. Specifically, Residents #24, #54, and #91 were care planned for hand rolls and were observed on multiple occasions without their hand rolls. Findings include: The 2/14/22 policy and Procedure Titled Splints and Bracing documented Splinting and Bracing are provided on order by the resident's primary physician or by the facility Medical Director. The purpose was to improve function and help restore or maintain range of motion. 1. Resident #24 was admitted to the facility with diagnoses including diabetes, Alzheimer's disease, and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (an assessment tool) dated 7/15/24 documented the resident had severe cognitive impairment and was dependent on staff for activities with activities or daily living. A care plan titled Palm guard care plan (Posey Roll) dated 7/25/24 documented interventions included bilateral Posey hand rolls to be worn as tolerated by resident. The hand rolls could be removed for bathing/dressing/range of motion and skin checks by nursing per their protocol. During observations on 08/27/24 at 9:34 AM and 11:42 AM, 08/28/24 from 8:50 AM to 11:41 AM, and 08/29/24 at 8:35 AM, Resident #24 did not have hand rolls in place. During an interview on 08/28/24 at 1:20 PM, a family member stated they were concerned about resident's hands as they have found the resident with their hands clenched and a smell coming from the inside of their hands on numerous occasions. They stated they had never seen the resident with hand rolls in place and had not observed the hand rolls in the resident's room. The family member stated they washed the resident's hands during visits, applied lotions and cut their fingernails as necessary. The family member stated a discussion regarding hand rolls had not taken place and they were not aware devices were available to resident. During an interview on 8/28/24 at 3:22 PM, Certified Nursing Assistant #3 stated they were not aware of resident wearing hand rolls. During an interview on 8/29/24 at 10:47 AM, Unit Supervisor Registered Nurse #1 stated that a care plan was in place for bilateral hand rolls for Resident #24. Registered Nurse #1 was unable to locate an order for bilateral hand rolls in electronic medical record during interview. They stated that communication did not occur between occupational therapy and nursing staff when the care plan was entered, and the order was not placed. They stated that order should have been placed by the occupational therapist when care plan was entered. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/29/24 at 1:21 PM, Certified Nursing Assistant #28 stated they were not aware of the resident wearing bilateral hand rolls. During an interview on 08/29/24 at 2:02 PM, Registered Nurse #26 stated that Resident #24 had not had hand rolls in place since they returned to the unit in early August 2024. Registered Nurse #26 stated they would usually report to physical therapy if a resident had contractures, or they would inform the supervisor. Registered Nurse #26 stated they did not report contractures to the unit supervisor or physical therapy. During an Interview on 08/30/24 at 9:39 AM, Occupational Therapy Assistant #25 stated they entered care plan for Palm Guard (Posey hand roll) on 7/25/24 at 8:29 AM. Occupational Therapy Assistant #25 stated they were asked to assess bilateral hands by a member of nursing team and entered care plans and progress notes after the assessment. They stated they issued Posey hand rolls to the resident and that occupational therapy supervisor would have been responsible for entering the order. Occupational Therapy Assistant #25 stated it was the responsibility of the Unit Supervisor and nursing staff to ensure hand rolls were placed on the resident daily. 2. Resident #54 had diagnoses including anoxic brain injury (lack of oxygen to the brain), dementia, and diabetes. A Quarterly Minimum Data Set (an assessment tool) dated 8/6/24 documented the resident's cognition was severely impaired, and the resident was dependent on staff for activities of daily living. The resident's care plan dated 7/9/24 documented Posey hand rolls to both hands. Interventions included to check skin every shift and as needed and check skin integrity. The Posey rolls could be removed for bathing/dressing/ range of motion, and skin checks. A Physician order dated 7/10/24 documented bilateral Posey hand rolls to increase comfort and limit skin breakdown to palms of hands; to be worn at all times except for hygiene and activities of daily living, and, skin checks. A review of the Treatment Administration Record for August 2024 did not include documentation regarding the hand rolls. A review of the Certified Nurse Aid accountability record August 2024 did not include the need for Posey Hand rolls. During an observation on 08/26/24 at 4:06 PM, the resident's hands were contracted, and the hand rolls were not in place. A hand roll was observed on the bedside table. During observations on 08/27/24 at 10:21 AM and 8/28/24 at 9:01 AM the resident was in bed and did not have Posey rolls in hands. During observations on 08/27/24 at 10:54 AM and 12:56 PM, the resident was in their geriatric chair, there was not a Posey roll in the left hand, and the right hand Posey roll was around the resident's wrist but not positioned in hand. (continued on next page)

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	335829	A. Building B. Wing	08/30/2024

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/28/24 at 12:38 PM the resident was in the dining room being fed by staff and did not have a Posey roll. During an interview on 08/28/24 at 12:38 PM, Physical Therapist #2 stated the resident should be wearing a left hand Posey and did not know why the resident was not wearing it. Physical Therapist #2 stated they were unaware the order was for bilateral Posey rolls. They stated If the resident refused to wear the rolls, the nurses should let them know and the resident would be reassessed. They stated they would also discuss with the physician if the resident was refusing the hand rolls. During an interview on 08/28/24 at 12:42 PM, Certified Nurse Aide #3 stated the resident threw the Posey hand roll at the staff this morning during morning care and they put them away in the bedside drawer. They stated they should have notified the nurse but did not. During an interview on 08/28/24 2:05 PM, Registered Nurse Supervisor #1 stated the Certified Nurse Aide did not notify them that the resident was refusing the Posey hand rolls. If a resident was refusing the hand rolls, they would inform therapy. During an interview on 08/28/24 at 03:04 PM, the Assistant Director of Nursing stated the hand rolls should have been in the Certified Nurse Aide task documentation and did not know why it was not activated on the care plan. They stated if the resident was refusing the hand roll it should have been documented by the nurse and the physician should have been notified. 3. Resident # 91 had a diagnosis of brain damage, chronic respiratory failure, and cardiac arrest. The 6/8/24 admission Minimum Data Set (resident assessment tool) documented the resident had severely impaired cognition and was dependent for other activities of daily living. The 7/10/24 Physician order documented right hand roll to increase comfort and maintain skin integrity. A 7/10/24 care plan documented a right hand roll due increased risk for contractures, and to decrease discomfort in right hand and decrease risk for skin breakdown. A 6/23/24 Certified Nurse Aide Care Card documented right hand roll on, and to remove for skin checks and hygiene. During observations on 8/26/24 at 10:15 AM, 8/27/24 at 10:00 AM, 8/28/24 at 2:00 PM, and 8/29/24 at 9:32 AM, Resident #91 was in bed, the left hand was open and the right hand was in a fist with no hand roll in place. During an interview on 8/30/24 at 10:15 AM, Registered Nurse #8 stated the Rehabilitation Department assessed the resident for the hand roll and when there was an order, nursing was responsible for ensuring the resident used the device. They stated if the resident was not wearing the device, a contracture may get worse or develop an open area. During an interview on 8/30/24 at 10:20 AM, Certified Nurse Aide #9 stated the staff was responsible for putting on the hand roll. They stated it was on the Kardex (care instructions), and they made sure it was on. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/24 at 10:30 AM the Director of Rehabilitation stated the Rehab Department was responsible for assessing the resident, providing the equipment and updating the care plan; nursing was responsible for ensuring the equipment was in place. 10 NYCRR 415.12(e)(2) 47626 50766

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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** 49255 Based on observation, record review and interviews during the recertification survey from 8/26/2024 to 8/30/2024, the facility did not ensure that each resident received necessary respiratory care including oxygen therapy that was in accordance with professional standards of practice and as ordered by the practitioner for 1 (Resident #308) of 4 residents reviewed for respiratory care. Specifically, for the Resident #308, the facility did not ensure the physician's order for the prescribed oxygen administration was followed. Findings include: Resident #308 had diagnoses including chronic respiratory failure with hypoxia, shortness of breath, and pneumonia. The Admission Minimum Data Set (resident assessment tool) dated 8/26/24 documented, Resident #308 was admitted to the facility on [DATE], had intact cognition, needed maximal assistance with toileting hygiene, shower/bathe self, lower body dressing, sit to lying, chair to bed transfer, and was dependent with toilet transfer. The resident had shortness of breath with exertion, sitting at rest, lying flat. The resident received oxygen therapy. During observations on 08/26/24 at 9:33 AM and 8/27/24 at 9:20 AM, Resident #308 was in their bed, wearing a nasal canula with a tube connected to the oxygen concentrator with 4 and 4.5 liters per minute flow oxygen. The resident stated that they were on the oxygen continuously since they were admitted to the facility. The physician order dated 8/21/24, documented continuous oxygen at 2-3 liters per minute via nasal canula. Review of the Treatment Administration Records dated 8/20/24 to 8/27/24 for 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM shifts, documented staff initials for oxygen at 2-3 liters per minute via nasal canula every day, every shift. During observation and interview on 08/27/24 at 11:55 AM, Resident #308 was in their room and receiving oxygen via nasal canula. Registered Nurse #21 observed the oxygen concentrator and turned the flow adjustment knob from 4.5 liters to 2 liters. Registered Nurse #21 stated the the order was for 2 liters per minute. Registered Nurse #21 opened their computer and reviewed the order and the August 2024 Treatment Administration Record and stated the order was continuous oxygen at 2-3 liters via nasal canula and did not know why the order was not being followed. 10 NYCRR 415.12(k) (6)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49364 Based on observation, interview and record review conducted during the recertification survey from 8/26/24 through 8/30/24 the facility did not ensure that sufficient nursing staff was consistently provided to meet the needs of residents on all shifts. Specifically, 1) multiple residents reported during interviews and the Resident Council Group meeting that the facility was short staffed at times, and this resulted in call bells not being answered timely and residents not getting out of bed; 2) several nursing staff members reported a lack of sufficient staffing; and 3) an analysis of the actual staffing schedule showed that on multiple occasions from 7/25/24 to 8/25/24, the facility was below the minimum levels documented on the Facility Assessment. Findings include: During a Resident Council meeting on 8/27/24, several residents stated that the facility was short staffed at times, especially on various shifts or on weekends. Residents stated that the call lights ring for a while before someone answers them; and some stated they had to stay in bed when they did not want to stay in bed. On 8/26/24 at 12:06 PM, during an interview with Resident #362, they stated when they rang the call bell, they had to wait for 2 hours to be taken to the bathroom and on several occasions the staff did not attend to their bathrooms needs and would only come to assist them when they were doing their cares. Resident #362 stated in the Residents' Council Group meeting on 8/27/24, they were late for their therapy session on two occasions because the staff got them out of bed late. On 8/27/24 at 09:31 AM, Resident #55 stated in the Resident's Council Group meeting the facility was short staffed on the weekends, and they had to stay in bed all day. Resident #55 stated this occurred last Sunday (8/25/24), they were in bed all day and was upset they could not get up. Resident #55 also stated the facility did not have enough staff to care for their needs. Review of the facility staffing sheets from 7/25/24 through 8/25/24, and the Facility Assessment for residents to direct care nursing staff ratios, documented the facility was understaffed 19 days of 31 days covering various shifts as reviewed for direct care nursing staff. In addition, on 8/25/24 the facility was understaffed of direct care nursing staff for 24 hours as reported in the Resident Council Group meeting on 8/27/24 where Resident #55 stayed in bed all day. On 8/28/24 at 11:06 AM, during an interview with Staffing Coordinator #12, they stated the facility utilized 4 staffing agencies to cover the regular staff vacations, medical leave, and resignations. The Staffing Coordinator #12 stated when there was short notice where the regular staff cannot cover their shift, another staff on duty would be asked to work a double shift before using the agency staff, this occurred two times weekly. On 8/29/24 at 8:49 AM, an interview with Certified Nurse Aide #3 stated they did a double shift for the facility at least three times per week. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/24 at 12:59 PM, an interview with Certified Nurse Aide #14 stated there were times it was impossible to get all the residents out of bed when the facility was short staffed. On 8/30/24 at 1:04 PM, an interview with Certified Nurse Aide #29 stated they prioritized by getting the residents that had therapy out of bed first when they were short staffed. They also stated when the facility was short of direct care workers, they could not get all 40 residents out of bed. They stated they did double shifts for the facility two times per week. On 8/30/24 at 1:14 PM, an interview with Certified Nurse Aide #6 stated they worked double shifts two times per week for the facility. On 8/30/24 at 2:19 PM, an interview with the Direct of Nursing (DON) stated the facility had good staffing of nurses and certified nurse aides. They stated the facility also had 3 helpers that assisted with answering the call bells, picking up the residents' meal trays and taking the residents' out for their appointments, but they did not give direct care to the residents. 10NYCRR 415.13(A)(1) (i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 49364 Based on staff interview and review of facility records during the recertification survey from 8/26/24 through 8/30/24, the facility did not ensure Certified Nurse Aides (CNAs) performance reviews were completed at least once every 12 months. Specifically, eight of eight randomly selected certified nurse aides (CNAs) (#3, #6, #14, #16, #17, #18, #19 and #20) did not have a performance review documented at least once every 12 months. Findings include: The Certified Nurse Aides (CNAs) (#3, #6, #14, # 16, #17, #18, #19 and #20) last performance evaluations were not available. Review of Certified Nurse Aides (CNAs) (#3, #6, #14, #16, #17, #18, #19 and #20) hire dates, provided by the facility, revealed all eight of the certified nurse aides had been working at the facility for more than one year, their hire dates ranges from 2002 through 2021. When interviewed on 8/29/24 at 8:49 AM, Certified Nurse Aide (CNA) #3 stated they could not recall when they had a performance evaluation done. When interviewed on 8/29/24 at 8:52 AM, Registered Nurse Unit Supervisor #1 stated they were responsible for Certified Nurse Aide yearly Performance Evaluations on the 3-11 shift, and they could not explain why they were not completed. When interviewed on 8/28/24 at 3:38 PM, Staffing Coordinator #12 stated the Nurse Educator/Supervisor #13 and the Nursing Supervisors were responsible for completing the Certified Nurse Aides' yearly performance evaluations. Staffing Coordinator #12 stated they were responsible for keeping tract of all the yearly performance evaluation when they were due. 10NYCRR 415.26 (c) (2) (iii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observations, record review, and interviews conducted during the Recertification Survey and Abbreviated Survey (NY00336677) from (,d+[DATE]-[DATE]), the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety and food prep equipment was clean and in safe operating condition. Specifically, 1) the walk-in refrigerator contained expired peanut butter and jelly sandwiches, and expired egg salad and peanut butter and jelly sandwiches were observed on prepared lunch trays, 2) Resident's personal food was observed in the resident pantry refrigerator beyond its 3 day limit; and 3) the first floor resident ice machine was not clean and observed with black slime on the inside of the machine which was in close contact with ice cubes. The findings are: During an initial tour of the kitchen on [DATE] at 9:28 AM, the walk-in refrigerator was observed with two peanut butter and jelly sandwiches in a large box that were stamped use by [DATE]. A second observation was made on [DATE] 11:46 AM on the food service line of staff preparing the hot meals and placing plates on the food truck preparing for delivery to Resident Units. One egg salad sandwich and 3 more peanut butter and jelly sandwiches stamped use by [DATE] were observed on the trays. During an interview on [DATE] at 12:06 PM with the Assistant Food Service Director they stated the trucks were prepared the day before and lunch meal trays with dry food, cold beverages and sandwiches were put on the trays. They stated they thought that when staff were doing the prep, they mistakenly left sandwiches on the truck dated use by [DATE]. During an interview with the Director of Food Service on [DATE] at 2:16 PM they stated they did not know why expired sandwiches were in the refrigerator and on meal trays but abiding by the use by dates were important because of Infection Control and prevention of illness. The stated food needed to be the freshest and staff just did not think ahead. 2) The facility policy titled Food Brought from Outside, dated [DATE], documented food will be held in the refrigerator for three days following the date on the label and will be discarded by staff upon notification to the resident. An observation was made on the first-floor resident refrigerator on [DATE] at 12:30 PM. Resident food in the refrigerator was dated [DATE] and another package was dated [DATE]. In addition, an undated ice cream cake was observed in the freezer. During an interview on [DATE] 12:52 PM, Licensed Practical Nurse #4 stated residents could keep food in the refrigerator for three days then it would be discarded. The refrigerator was supposed to be checked every day for expired food by Certified Nursing Assistants but did not know why it had not done in a while. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On [DATE] at 12:23 PM the lower-level ice machine located in the resident pantry was observed to have a large patch of black slime inside the machine on the right side of the ice tray and on the inside walls of the box. The tray automatically turns on its side when ice is ready and falls down the wall of the machine to the collection unit. The machine was full of ice cubes which fell from ice tray. A dark substance was observed on the bottom of the ice trays. During an interview on [DATE] at 08:35 AM, the Director of Housekeeping stated the Housekeeping Department was responsible for cleaning the ice machines. They stated the last cleaning was [DATE], and was not aware there was a problem, but housekeeping staff should have informed them it had black slime. The Director of Housekeeping stated it was important to keep the ice machines clean since there were a lot of hands going in and out of the machine with each use that could contaminate the ice. 10NYCRR 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41666 Based on observations, record review, and interviews during a Recertification Survey (8/26/24-8/30/24), the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection. Specifically, 1) the facility did not ensure that an infection surveillance plan based on facility assessment was implemented for identifying, tracking, and monitoring infections, communicable diseases, and outbreaks. 2) the facility Water Management Plan for Legionella had not been reviewed annually, 3) the facility did not ensure that 9 of 10 staff members were offered and educated regarding the risks and benefits of the pneumonia vaccination and given the opportunity to decline or receive the vaccination; and 4) did not properly implement Enhanced Barrier Precautions for 4 of 24 residents (#6,#307,#309 and #24). The findings are: 1) The infection tracking logs documented infections that were being tracked for the month of July 2024. There was no documentation during July 2024, August 2024 that could be reviewed for infection onset dates, signs and symptoms, lab tests/results, isolation, and outbreak potential. During an interview on 08/28/24 at 10:43 AM with the Infection Preventionist who stated the line list of infections for June was not found and August line list was not done yet but will be doing it soon since it is done at the end of the month. The Infection Preventionist does not track infections as they are happening and currently did not know if there were any patterns of infections occurring to identify and prevent the spread of further infections. During an interview with the Director of Nursing on 8/28/24 at 12:25 PM they stated they did not have a tool to document infection tracking and knows about the different infections in morning report. The Infection Preventionist is supposed to be taking notes of the infections in real time because that is part of their Infection Preventionist job. The Director of Nursing stated this needs to be done to catch a cluster of infections to prevent them from spreading. 2)The Water Management Plan for Legionella prevention was reviewed and dated December 2016 and there was no documentation the plan was reviewed and if needed revised annually. During an interview with the Director of Maintenance on 8/26/2024 they stated they were aware the plan needed to be reviewed and updated yearly for accuracy but did not realize it had been since 2016. 3) A review of the immunization records of 7 out of 10 randomly selected employees (#22 #33,#34, #35, #36, #37, #38) indicated that education regarding the risks and benefits of pneumonia vaccination was not provided. There was no documented evidence that the vaccine was offered and/or received or that the employees declined to receive the vaccination and were provided education. During an interview with the Infection Preventionist on 08/27/24 at 02:40 PM they stated they don't offer the pneumococcal routinely because no one wants it but did not have declinations from staff to review. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on 08/30/24 01:58 PM they stated the Infection Preventionist should be keeping track of vaccines and does not know why it is so disorganized. 4) Resident #307 had diagnoses of anemia, dementia, and dysphagia. The physician orders dated 5/30/24 documented Enhanced Barrier Precautions for heel wound and right hip surgical wound. Resident#309 had diagnosis of anemia, dementia, and hypertension. The physician's orders dated 8/26/24 documented Enhanced Barrier Precautions for surgical wound. During an observation and interview with the Infection Preventionist on 8/28/24 at 10:43 AM on the first-floor unit, Resident #307 and Resident #309 rooms were viewed. There were no doffing pails and no supply carts in the hallway for easy accessibility. The Infection Preventionist stated carts need to be conveniently located outside the resident's rooms, so staff are not walking around in the hallway looking for additional supplies. The Infection Preventionist stated they did not know why this was not done but it should be in place. 10NYCRR 415.19(a)(2) 50766

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335829	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER: Adira at Riverside Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41666 Based on record review and interview during the recertification survey conducted 08/26/24 to 08/30/24, the facility did not ensure each resident was offered pneumococcal immunizations and received education regarding the benefits and potential side effects of the immunizations for 1 of 5 residents (Residents #91) reviewed. Specifically, there was no documented evidence Resident #91 was offered, declined, or educated on the pneumococcal immunization. Findings include: The undated facility policy titled Resident Pneumovax Vaccination Program, documented the Pneumovax is to be given to all residents who have no prior evidence of receiving it. All new admissions are to be assessed for the need for this vaccine as part of the admission medical work up. Residents will be provided with instruction and education relative to Pneumovax and aspects of our vaccination program. The education will be given on admissions as well as prior to the implementation of our immunization program and may consist of fliers and fact sheets. All education will be documented on the Resident Consent /Declination form in the comprehensive care plan and or nurse's notes for validation. Resident #91 had diagnoses of respiratory failure, seizures and was ventilator dependent. There was no documented evidence that the resident/resident representative received education, was offered the vaccination, or declined the pneumococcal vaccine. During an interview on 08/28/24 at 12:05 PM, with the Infection Preventionist they stated vaccines for residents was important because they provided good protection against disease for residents. There was not one person in charge of obtaining vaccine information for the residents and left it up to the Nursing Supervisors to get consents and write notes. The Infection Preventionist had no tool with Resident information and vaccine status and did not know which residents were eligible, declined or were provided education about pneumococcal vaccine. The Infection Preventionist stated they did not keep a record of declinations from residents and/or residents representative. During an interview with the Director of Nursing on 08/30/24 at 1:58 PM, they stated the Infection Preventionist should be keeping track of vaccines for residents and staff and did not know why it was so disorganized. The Director of Nursing stated they needed to track vaccine status better. 10NYCRR 415.19 (a) (1-3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335829	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adira at Riverside Rehabilitation and Nursing	120 Odell Avenue 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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41666 Based on interview and record review during the recertification survey conducted 08/26/24-8/30/24, the facility did not ensure each staff and resident was screened, offered the COVID-19 vaccine and provided education regarding the benefits, risks and potential side effects associated with the vaccine for 1 of 5 residents and 1 of 10 staff reviewed for COVID vaccines. Specifically, there was no documented evidence of immunization records for COVID vaccines for Resident #91 and Staff #37. Findings include: The facility policy titled COVID-19 Vaccination for Residents and Staff and last revised 5/13/21 documents in order to prevent the spread of infectious disease and to decrease the morbidity and mortality associated with the SARS-Co V-2 virus the facility will offer vaccine to all residents and residents/resident representatives will be provided education. Resident #91 had diagnoses of respiratory failure, seizures and was ventilator dependent. There was no documented evidence that the resident/resident representative received education, was offered the vaccination, or declined the COVID vaccine. During the recertification survey the facility was asked to provide the vaccination status for flu, pneumococcal and COVID vaccines. There was no documented evidence the facility had documentation of screening, education offering or current COVID19 status for Resident #91and Staff #37. During an interview with Infection Preventionist on 08/27/24 at 2:40 PM, they stated they dealt with the vaccines that were given in facility, but the ones given outside were kept in a separate binder. The current Staff and Resident files were not in order. The Infection Preventionist stated they did not have records of staff or residents who were offered, declined, and were educated on COVID vaccines. They stated they did not keep track or follow up with staff who had not provided their vaccine history and did not think Staff #37 workedat the facility. During an interview with the Registered Nurse Supervisor #22 on 08/28/24 at 10:22 AM, they stated when a new admission resident came into the facility, they would look up vaccine information in their record and whatever was missing they would pass on to the next supervisor. They stated there was no way to keep track or follow up on it as it just gets passed down to the next person. During an interview with Respiratory Therapist #37 on 08/30/24 at 01:30 PM, they stated they worked per diem roughly once a week for the past two years and brought their supervisor their vaccine records. They stated they had not been approached by the Infection Preventionist about their vaccine status or offered any additional vaccines during that time. During an interview with Certified Nurses Aide #39 on 8/28/24 at 10:28 AM, they stated they had been at the facility for 2 years and had not been offered the current COVID booster vaccine. (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 B. Wing	08/30/2024

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

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nurses Aide #40 on 08/30/24 at 10:11 AM, they stated they had the original COVID series of 2 vaccines but had not been offered a booster at the facility. 10NYCRR 415.19 (a)(1-3)