STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335848	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Kendal on Hudson		STREET ADDRESS, CITY, STATE, ZIP CODE One Kendal Way Sleepy Hollow, NY 10591	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the recertification and abbreviated surveys (NY00321462) from 4/30/24 to 5/06/24, the facility did not ensure adequate supervision was provided and that the residents environment remained as free of accidents hazards as possible for 2 of 4 residents (Residents #18 and #74) reviewed for accidents. Specifically, (1) Resident #18 whom has a history of falls with major injuries, was observed on multiple occasions without their floor mats in place to the sides of their bed. (2) Resident #74 who had exit seeking behavior, was not provided adequate supervision and was able to exit the facility undetected by staff. Resident #74 followed visitors out of the facility and was found in the hospital parking lot by hospital staff. The findings are: 1. Resident #18 was admitted to the facility with diagnoses including but not limited to a right hip fracture, intertrochanteric fracture of the right femur, and rhabdomyolysis. The 04/24/2024 Quarterly Minimum Data Set (assessment tool) documented that Resident #18 had severely impaired cognition, and required total assistance with toileting and, extensive assistance with bed mobility, set up with eating, and transfers did not happen. Furthermore, the 04/24/2024 Quarterly Minimum Data Set Documented Resident #18 had recent surgery due to fracture requiring a skilled nursing facility. The facility policy titled Floor Mats/Safety dated 2017 documented facility will utilize a floor mat/s to prevent injury to a resident from fall out of bed onto the floor. Care plan will reflect the need for Floor mat/s based on the resident's cognitive ability and assessed by the interdisciplinary team for use. Resident who has a history of attempting to exit the bed without assist may be a candidate. The At risk for accidents/falls/injury Care Plan dated 1/30/24 documented diagnosis of left hip fracture status post left hip fixation on 10/15/23. Goals included Resident #18 will have safety measures maintained to lessen any injury from a fall. Interventions included floor mats is to be on both sides of the bed. On 04/30/24 at 11:04 AM, Resident #18 was observed in their room lying in bed. There were no floor mats in place to either side of the bed. The floor mats were observed folded up behind a chair. On 05/01/24 at 11:50 AM, Resident #18 was observed awake lying in bed. There were no floor mats in place to either side of the bed. Floor mats were folded up behind a chair. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335848	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kendal on Hudson	One Kendal Way Sleepy Hollow, NY 10591

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/03/24 at 09:15 AM and 10:17 AM, Resident #18 was observed lying in bed. The bed was in highest position and the right floor mat was observed on the wall, and not in place on the side of the bed. During an interview on 05/03/24 at 10:18 AM, Staff #2 (registered nurse unit manager) and Staff #9 (registered nurse) stated the resident should have had floor mats on both sides of the bed and the bed should have been in the lowest position. During an interview on 05/03/24 at 10:20 AM, Resident #18's son stated that six weeks after admission for a left hip fracture, the resident fell out of bed resulting in a fracture of the right hip and stated the resident should have their floor mats in place. During an interview on 05/03/24 at 10:41 AM, Staff #10(certified nurse aide) stated that they were aware Resident #18 was supposed to have floor mats on both sides of the bed for safety due to history of falls. 48850 2. Resident #74 had diagnoses of dementia, depression, and delusional disorder. The Minimum Data Set (a resident assessment and screening tool) dated 07/14/2023 revealed the resident was severely cognitively impaired. The MDS documented the resident needed limited assistance on transfer, walk in room, walk in corridor with which occurred once or twice with one person. A wander alarm to be used daily. The undated facility policy titled Elopement Prevention documented that residents who were identified at risk for elopement would have individualized interventions implemented to decrease the risk of elopement and to keep the resident safe. The comprehensive care plan, titled Potential for Wandering/Elopement, initiated on 06/21/2023, outlined interventions to assess Resident #74 for wandering/elopement tendencies. It included the initiation of a wander guard system and ongoing evaluation of its necessity based on the resident's pattern of wandering. The plan specified ensuring the resident wears an ID band and that the wander guard is properly placed on the left ankle and checked for functionality during every shift. Staff were instructed to monitor the resident for any attempts to exit the building, document circumstances, employ redirection interventions, and record outcomes. Additionally, caregivers were tasked with providing structured and supervised walking activities, reorientation, scheduled opportunities, and pleasant diversions to distract the resident from wandering, such as engaging in activities of interest, watching television, or reading. The care plan updated 07/26/2023, documented Resident #74 continued to benefit from the wander guard on their ankle. The resident was exit seeking and looked for their spouse. The care plan goal was the resident would not be exit seeking or leave the facility unattended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing progress note by Staff #15 (licensed practical nurse) dated 08/02/2024 at 5:59 PM documented Resident #74 was redirected throughout the day, with frequent monitoring for safety due to frequent attempts to leave the unit. The wander guard (electronic monitoring device) was in place and functioning. Resident #74 continued to be pleasantly upset as they were unable to leave the unit. The resident was observed wandering on the unit in a wheelchair throughout the day, self-propelling and transferring independently. The nursing progress note by Staff #15 dated 8/3/2024 at 4:19 PM documented at 2:15 PM the resident was self-propelling their wheel chair with their feet on the unit. At 2:30 they were unable to locate the resident and at 2:45 PM the resident was located and assisted back to the unit. The accident/incident report dated 08/03/2023 at 2:30 PM, documented the resident was not found during medication pass, prompting notification of the family, who denied having taken the resident with them from the unit. Between 2:35 and 2:40 PM, the Director of Nursing and Director of Social Work initiated a search for the resident, activating a missing resident (code Green). The Director of Resident Services reported that they saw the resident on the unit between 2:10 and 2:15 PM. At 2:43 PM, a former employee, now working at the hospital, called the Director of Resident Services to inform them that the resident was in the hospital parking lot. Resident #74 was then escorted back to the facility and physically returned to the facility at 2:45 PM. The report documented that the wander guard bracelet placed on the resident's ankle was tested , and its proper function was verified. During an interview on 05/03/2024 at 11:00 AM, the Director of Nursing stated that the resident followed two visitors who were exiting the building. The Director of Nursing stated the resident was on 15-minute checks before the incident occurred, and although the wander guard was functional, it did not have an alarm activated at the time. During an interview on 5/6/2023 at 4:30 PM, Staff #15 stated that on the day of the elopement, they had seen Resident #74 around 2:15 PM. Staff #15 stated that the resident was on 15-minute checks prior to the elopement incident on 08/03/2023 and the Certified Nurse Aides were responsible for completing the forms but did not know where the forms were. Staff #15 stated they could not recall when the 15-minute checks were implemented and had seen the resident wandering throughout the day. Further review of the written statements dated 8/3/24, by Staff #13, Staff #16 and Staff #17 (all Certified Nurse Aides) documented the last time any of them saw the resident was at 1:40 PM. During an interview on 5/6/2024 at 5:17 PM, Staff #13 stated that on 08/03/2023, Resident #74 was not on their assignment. Staff #13 remembered seeing the resident outside room [ROOM NUMBER] and instructed them to return to their room. However, when returning from assisting another resident, Resident #74 was no longer present. Staff #13 stated they had not been informed of any increase in exit-seeking behavior exhibited by Resident #74 that day. 10NYCRR 415.12(h)(1)