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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kendal on Hudson	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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48850 Based on interviews and record reviews conducted during a Recertification Survey from 04/30/2024 to 5/06/24, it was determined that for 2 of 16 residents (Residents #5 and #14), the facility did not ensure that preadmission screening for individuals identified with an intellectual disability (ID) was fully completed prior to admission, in order to receive care and services in the most integrated setting appropriate to their needs. Specifically, the Pre-Admission Screen Resident Review (PASRR) for Resident #5 and #14, dated 02/29/2024 and 02/23/24 respectively, lacked a screener identification number. Findings include: Resident #5 was admitted on [DATE] with a diagnosis of Alzheimer's/dementia and depression. The Minimum Data Set (a resident assessment and screening tool), dated 03/07/2024, documented the resident had moderately impaired cognition. Resident #14 was admitted to the facility on [DATE] with a diagnosis of Conversion Disorder with seizures, dementia, and delusional disorder. The Minimum Data Set, dated dated [DATE], documented the resident had severely impaired cognition. On 05/06/2024, Preadmission Screening and Resident Review forms were reviewed for 16 residents, revealing that 2 of them were missing the screener's identification number on item 38. The facility policy titled Pre-Admission Screen/Annual PASARR, with a revised date of 2023 documented that all residents must have PASARR screen prior to admission to the facility and thereafter when there is a significant change that has a bearing on the residents will be reviewed thoroughly prior to admission. During an interview on 05/06/2024 at 2:20 pm, the social worker acknowledged the issue concerning the two PASARRs lacking the required ten/twelve-digit ID. NYCRR 415.11 (e)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 39308 Based on record review, interview and observation during the recertification survey conducted from 4/30/24 through 5/6/24 the facility did not ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition for 1 of 2 residents (Resident #1) reviewed for activities of daily living. Specifically, Resident #1 who required staff assistance for eating was observed on 2 occasions being fed by a companion (no hands on care). The findings are: The policy and procedure titled Private Companion in the Health Center with a revision date of March 2023 documented the role of the companion included assisting at mealtimes with menu selection, setting up utensils, opening containers. No personal hands on care shall be provided by the companions without proper level of certification/licensure. Resident #1 was admitted with diagnoses including but not limited to osteoporosis, non alzheimer dementia, and anxiety. The 3/1/21 Certified Nurse Assistant Activity of Daily Living Tasks documented Resident #1 required assistance for eating. The 4/1/22 Certified Nurse Assistant/Companion Plan of Care Record documented certified nurse assistant/companion diet soft, encourage fluids/food was checked off daily and the certified nurse assistant section for eating did not give directives for feeding the resident/was not checked off daily. The 3/22/23 physician order documented may have meals in bed. The 5/26/23 physician order documented soft diet/bite sized. The 12/5/23 Quarterly Minimum Data Set and 3/4/24 Comprehensive Minimum Data Set documented Resident #1 had moderate cognitive impairment, was dependent with eating, and received a mechanically altered diet. The 3/12/24 care plan titled Risk for Weight Loss/Dementia documented mechanically altered diet. Interventions included team members to encourage completion of foods/fluids/supplements and to monitor meal intakes and offer alternatives. The 3/12/24 care plan titled Activities of Daily Living Self Care documented interventions including, resident will be assisted to perform eating swallowing with close supervision. Observe for decline in the activity of eating and the ability to feed self with no assistance. During observation on 4/30/24 at 12:09 PM Resident #1 was in bed with the head of the bed up. Staff #1 (Companion) was feeding Resident #1 their lunch meal which consisted of a shake, chocolate cake, pureed soup, mixed vegetables, chopped spaghetti and a protein. Facility staff were not present at the time of observation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 5/1/24 at 8:33 AM Resident #1 was in bed with the head of the bed up. Staff #1 was feeding Resident #1 their breakfast. Facility staff were not present at the time of observation. The 5/2/24 facility companion/certified nurse assistant list documented that Resident #1 had a companion. During an interview on 5/3/24 at 9:42 AM Staff #1 stated they were a companion. Staff #1 stated at times, after facility staff delivered the resident meals they fed Resident #1 because the resident liked that. Staff #1 stated that they reported resident meal intake to the facility registered nurses. Staff #1 stated they had not received training/in-service from the facility but did receive annual in-service through the home care agency. Staff #1 stated they should not feed Resident #1 but if the facility staff were busy and the resident was requesting their food, rather then having the food sit there, they fed the resident. During an interview on 5/3/24 at 11:02 Staff #2 (Registered Nurse Manager) stated Staff #1 was not supposed to feed Resident #1 because Staff #1 was a companion and not a certified nurse assistant. Staff #2 stated they and/or the certified nurse assistants were responsible for supervising Staff # 1. Staff #2 stated they were not aware that Staff #1 had been feeding Resident #1. During an interview on 5/3/24 at 12:23 PM the former Director of Nursing stated companions were to provide comfort/company and were not allowed to feed residents, as they were not trained. The former Director of Nursing stated that facility certified nurse assistants delivered meal trays to resident rooms, and the licensed practical nurse was responsible for oversight of lunchtime trays in resident rooms and ensuring appropriate staff were feeding the residents. The former Director of Nursing stated that registered nurses were responsible for oversight of the dining room and overseeing the licensed practical nurses. The former Director of Nursing stated there appeared to be a system problem in identifying the credentials of agency staff. 10 NYCRR 415.12

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48847 Based on observations, record review and interviews conducted during the Recertification Survey from 4/30/24-5/6/24, the facility did not ensure 1 of 2 residents (Resident #19), reviewed for positioning, received treatment and care in accordance with professional standards of practice. Specifically, Resident #19 was observed on multiple occasions sitting in their wheelchair without footrests, legs were dangling, and feet were not touching the floor. The findings are: The facility policy titled Wheelchair Positioning dated 12/2004 and updated in 2023 documented it is the policy of the Rehabilitation Department to provide functional, safe, and comfortable wheelchair positioning to all residents at the time of admission or as identified at any time the need for a new evaluation. Resident #19 was admitted to facility on 04/04/24 with diagnoses including but not limited to Alzheimer's disease, anxiety disorder, hypothyroidism, and muscle weakness. The Comprehensive Minimum Data Set, an assessment tool, dated 4/10/24 documented the resident had severely impaired cognition, required total assistance with eating and toileting and extensive assist with bed mobility and transfers. Furthermore, the Minimum Data Set documented that Resident #19 required a wheelchair. The Adaptive/Safety Equipment/Repositioning Care Plan dated 4/23/24 documented the resident will utilize assistive devices properly with teaching and appropriate selection of equipment. Interventions included that resident is currently using a reclining wheelchair. On 04/30/24 at 10:52 AM, Resident #19 was observed sitting in high back wheelchair in the dayroom asleep at the table. There were no footrests in place and feet were dangling. On 04/30/24 at 12:25 PM, Resident #19 was observed in the dining sitting in their wheelchair with both legs elevated and dangling above the ground. There were no leg/footrests in place. On 04/30/24 at 12:45 PM, Resident #19 was observed being wheeled in their wheelchair to the dayroom with both legs elevated and dangling above the ground. There were no leg/footrests in place. On 05/03/24 at 9:05 AM, Resident #19 was observed sitting at the table eating breakfast and legs were dangling and footrests were not in place. On 05/03/24 at 09:25 PM, Resident #19 footrests were observed in their bathroom underneath the sink and the resident was in the dayroom. During an interview on 05/03/24 at 9:27 AM, Staff #6 (certified nurse aide) stated that they were aware that Resident #19 was supposed to have footrests on their wheelchair and that they were rushing and unable to put them on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/03/24 at 09:27 AM, Staff #7 stated that Resident #19 was supposed to have footrests on the wheelchair for safety and comfort and was not sure as to why the certified nurse aide did not put them on. During an interview on 05/03/24 at 01:40 PM, Staff #2 (registered nurse unit manager) stated that Resident #19 should have footrests on their wheelchair and that their legs should not be dangling. During an interview on 05/03/24 at 03:13 PM, Staff #8 (occupational therapist) stated that on admission the resident was received in the chair with footrests and that all wheelchairs had leg rests. They stated the leg/footrests should be used unless an evaluation was done and it was determined that there was no need for the use of footrests. During an interview on 05/03/24 at 03:56 PM, the Director of Rehabilitation stated that it was expected that any changes with resident's activities of a daily living, the therapy department should be documenting and communicating with nursing. 10NYCRR 415.12

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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. 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 47626 Based on observations, interviews, and record review conducted during the recertification survey, 4/30/2024-5/6/32024 the facility did not ensure that special eating equipment and utensils for a resident who need them was provided for 1 of 1 resident (Resident #9) reviewed for adaptive equipment. Specifically, built up (red foam) utensils were not provided for Resident #9 as per physician order. The findings are: A policy and procedure titled Adaptive Devices dated June 2005 last revised 2023 documented the purpose was to provide residents with device/s to ensure eating independence. Resident #9 had diagnoses including chronic obstructive pulmonary disease, lymphedema, and unspecified hearing loss. The physician order dated 11/13/2023 documented a 3-compartment plate, a regular diet, and (red foam) built up utensils with all meals. The Quarterly Minimum Data Set (an assessment tool) dated 3/9/2024 documented the resident's cognition was moderately impaired. The resident required set up assistance, for eating and all other activities of daily living required substantial to maximal assistance. During observations on 04/30/24 and 5/1/2024, lunch was served in the resident's room, no built-up utensils were noted on the tray. During an observation on 05/01/24 at 09:38 AM breakfast was served while the resident was in bed. The resident's tray was noted to have a 3-section plate, and no built-up utensils had been provided. During an observation on 05/02/24 at 12:18 PM during lunch there were no built-up utensils on the tray. The resident had difficulty holding the fork and spilled food down the front of their clothes when attempting to eat coleslaw. During an observation on 05/03/24 at 09:12 AM the resident was in bed with breakfast tray. Built-up (red Foam) utensils were present on the tray and the resident was using them. The resident ate 100% of her meal. During an interview on 5/2/24 at 1:32 PM Staff #3 (Certified Nurse Aide) stated the resident received set up assistance with meals, they gave the resident finger food, and the resident had built up utensils in the past, but not recently. They thought the utensils should come from the kitchen. During an interview on 5/2/24 at 1:32 PM Staff #4 (Certified Occupational Therapy Assistant) stated they had recommended a 3-section plate and built-up utensils. Therapy provided them to the kitchen for Resident #9 and they had even left one in the resident's room for the resident to use. Staff #4 stated they did not know what happened to the utensils. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/24 at 2:22 PM the Director of Nursing stated they communicated with the Interdisciplinary Team, when a physician wrote an order, to ensure all orders were carried out. The built- up utensils would come from the kitchen and should be listed on the resident's menu. During an interview on 5/2/24 at 2:33 PM Staff #5 (Certified Dietary Manager) stated they did not receive the order for the built-up utensils. The process would be for therapy to make a recommendation, an order placed by the physician, and the nurse would provide the dietitian with a slip indicating the changes. The dietitian would care plan and update the roster to include the changes, and adaptive equipment would be listed on the resident's menu. During an interview on 05/03/24 at 09:14 AM, Resident #9 stated the special utensils did help them a little to eat. Resident #9 stated they would use them if they were available. 10 NYCRR 415.14 (g)

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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** 48850 Based on observation and interview conducted during a recertification survey from [DATE] to [DATE], the facility did not ensure that food was stored in accordance with professional standards for food safety practice, Specifically, multiple food items were found with expired dates, leftover foods were unlabeled, and dented cans were found. The findings include: Observation and interviews from the kitchen initial tour conducted on [DATE] at 9:45AM with the sous-chef revealed: - a half used country mustard with an expiration date of [DATE]; - a dill weed container with the expiration date of [DATE]; - a white pepper container half used without the opened date and expiration date; - 2 unopened Coleman's mustard containers had expiration dates of [DATE] and [DATE]; - 2 dented cans of black beans; - arrowroot used approximately 80% without an opened date or expiration date; - sliced cake in the freezer without proper label, labeled ,d+[DATE] - ,d+[DATE]; and - a dirty smoke liquid bottle with date barely visible. During an interview on [DATE] at 9:50 AM, the sous-chef stated all of the expired goods should have been not been left in stock and should have been thrown out. They stated the sliced cake in the freezer could be kept for a week and that it was incorrectly labeled. During an interview on [DATE] at 10:05 AM, the Dining Service Director stated the expired dill weed, white pepper, and other expired products should have been removed from circulation. They also stated the dented cans should have been removed from inventory to ensure food safety. 10NYCRR 415.14 (h)