STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335515	A. Building B. Wing	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yonkers Gardens Center for Nursing and Rehab	115 South Broadway 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626 Based on observation, interviews, and record reviews conducted during the Recertification Survey from 8/11/23 to 8/15/23, it was determined the facility did not ensure a resident's care plan was revised to reflect the resident's change in condition for one of one resident (Resident #102) reviewed for Incontinence of Bowel and Bladder. Specifically, when Resident #102 had a decline in continence of bowel and bladder, the care plan was not updated. Findings include: Review of the undated facility policy, Comprehensive Care Plan, revealed that the resident's care plans would be revised as changes in the resident's condition dictates. Resident #102 had diagnoses including Schizophrenia, brain cancer, and obesity. A quarterly Minimum Data Set (MDS, an assessment tool), dated December 09, 2022, documented the resident was always continent of bowel and occasionally incontinent for bladder. An annual MDS dated [DATE], documented the resident was always continent of bowel and frequently incontinent of bladder. A quarterly MDS dated [DATE] documented the resident was occasionally incontinent of bowel, and frequently incontinent of bladder. A Care Plan for incontinence of bladder dated 9/26/2022 with goals to be free from Urinary Tract Infection, and no decline in skin breakdown related to incontinence. The interventions included incontinence pad, monitor peri area for skin incontinence. The care plan was last reviewed 7/12/2023 and no revisions were made and bowel incontinence was not addressed. During an observation on 08/10/23 at 11:46 AM, a bag containing the resident's soiled underpants was observed on the floor next to the bed. During an interview on 08/11/23 at 01:44 PM, the Certified Nurse Aide (CNA) #5 stated the resident had urine leaking sometimes and they had not noticed that the resident had bowel incontinence. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/11/23 at 02:00 PM, the Director of Nursing (DON) stated they currently did not have anyone on a toileting program. The DON stated they expected the CNA to report changes in the residents condition the nurses. The DON stated they were not sure how they would know if the resident was having more incontinent episodes and it was up to the nurse manager to update the care plan. During an interview on 08/14/23 at 09:55 AM, Registered Nurse (RN) #7 stated they had only worked at the facility for about 1 month and did not know that the resident had increasing incontinence. During an interview on 08/14/23 at 10:00 AM, the MDS coordinator stated they reviewed the medical record and they read everything. They stated they code Section H for bowel and bladder, and would not necessarily notice a change in continence. The nurses on the unit should have identify a decline in continence and were responsible for updating the care plan. 10 NYCRR 415.11(c)(2)(i-iii)

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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** 44673 Based on observation, record review and interview conducted during a recertification survey and abbreviated survey conducted from 8/9/23-8/15/23(NY00315357) the facility did not provide adequate supervision to prevent elopement for 1 of 5 residents reviewed for accidents. Specifically, Resident #237 left the facility undetected by staff on 4/23/23 and was not found until 4/24/23 when the facility found the resident had been admitted to a hospital. Findings include: The Policy and Procedure titled Elopement Prevention dated 10/2018, documented the facility will utilize all possible measures to maintain the safety and well-being of all residents. The facility will have systems and tools in place to prevent unsafe wandering and or elopement. Resident #237 had diagnoses of Unspecified Dementia with Behavioral Disturbance, and Major Depressive Disorder. The Quarterly Minimum Data Set (MDS, a resident assessment and screening tool) dated 2/10/23 revealed the resident was severely cognitively impaired. The MDS documented Resident #237 had wandering behavior, required limited assistance with transfers, walking in room and corridor as well as locomotion on and off unit. An Elopement Risk assessment dated [DATE] revealed that the resident had a history of elopement and was at risk for elopement . The assessment documented the resident had attempted leaving the facility without informing staff. The resident had verbally expressed the desire to go home, often packed belongings to go home, and stayed near an exit door and also wander aimlessly. The Person-Centered Care Plan titled At Risk for Elopement was initiated on 2/6/2023, with a goal that Resident #237 would not elope from facility within the next 90 days. The interventions included approaching the resident calmly and redirecting resident. Review of the Incident report dated 4/23/2023 documented at approximately 4:08 PM Resident #237 was noted missing during a scheduled smoking period. The facility's investigation concluded the resident eloped during a supervised smoking period in the facility. During an interview on 8/14/2023 at 10 AM, the Director of Nursing (DON) stated since the 4/23/23 incident they made the smoking area more secure. Observation of the smoking area, with the DON present, revealed an enclosed area for the residents to smoke and the supply cart and the staff monitoring were located outside the smoking area. During an interview on 8/14/2023 at 10 AM, Resident #41 stated they were there when Resident #237 was smoking and disappeared. The monitor gave them their cigarettes and was outside of the smoking area. No one saw what happened and then the staff was searching for him. (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 8/15/23 at 10 AM, Smoking Monitor #1 stated that on 4/23/23 Resident #237 came downstairs and was given a cigarette and went to the smoking area. The smoking monitor stated they stood outside the patio. The monitor stated that they looked for something in the supply cart and when they looked back, did not see resident. The smoking monitor stated another resident stated Resident #237 hopped the fence. The smoking monitor stated the Supervisor and Assistant Administrator were notified and a code purple was called. During an interview on 8/14/23 at 8:15 PM, LPN #1 stated resident was anxious and trying to leave the unit to go to smoke and the resident was taken to the smoking area. LPN #1 stated the CNA was asked to go check on Resident #237 and found the resident was not in the smoking area when the CNA arrived. The LPN stated they called the supervisor and Code Purple was called. During an interview on 8/14/2023 at 9:41 AM, the Nursing Supervisor RN #3 stated they were made aware on 4/23/23 at around 4:10 PM that the resident was missing and went to the smoking area to search. A Code Purple was called and we were unable to find the resident. During an interview on 8/15/2023 at 1:55 PM, the Director of Nursing (DON) stated the resident was at risk for elopement and was on enhanced supervision. Nursing was to escort him to the smoke patio he would be escorted back to the unit. During an interview on 8/15/2023 at 11:20 AM, the Assistant Administrator stated on 4/23/23 they were notified Resident #237 eloped and the Code Purple was called. They stated they drove around the area and the search was unsuccessful; 2 days later Resident #237 showed up at the hospital.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44673 Based on observation, record review and interview conducted during a recertification survey from 8/9/23 to 8/15/23. The facility did not ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 5 residents reviewed for Medication storage. Specifically, Resident #64 had a bottle of unlabeled Mucinex at his bedside. Findings include: The Policy and Procedure titled Medication Administration revised 2/4/2020 documented medications should be administered as ordered by the physician. Only licensed Personnel are assigned responsibility preparing administering and recording medication. Resident #64 was admitted with Malignant Neoplasm of Esophagus, Dysphagia and Muscle wasting. The Quarterly Minimum Data Set (MDS, a resident assessment and screening tool) dated 5/5/23 revealed the resident had intact cognition. The MDS documented Resident #64 had no swallowing disorder and required supervision and set up help only for eating. The Care Plan dated 9/6/2022, documented Resident #64 was at risk for aspiration related to esophageal cancer. Interventions included checking for appropriate medication form, and may crush appropriate medications and mix with applesauce per physician orders, and to facilitate medication administration. During observations on 8/9, 8/10, 8/11, and 8/14/2023,a bottle of Mucinex was on resident night stand unlabeled. During an interview on 8/9/23 at 10 AM, Resident #64 stated they had a cold and took Mucinex. They stated it was helpful and not provided by the facility. A physician order dated 8/14/2023, documented Mucinex Fast-max chest congestion oral liquid, give 10 milliliters by mouth every 8 hours. During an interview on 8/15/23 at 10:17 AM, licensed practical nurse (LPN) #2 stated they were unaware the resident had the medication at the bedside and if they had noticed it, they would have removed it and gotten a physician order. During an interview on 8/15/23 at 10:15 AM, registered nurse (RN) #5 stated resident had a cough and purchased the Mucinex. RN #5 stated it should not have been at the bedside. 415.18

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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 record review and interview conducted during a recertification survey from 8/9/23 to 8/15/23, the facility did not properly establish and/or maintain an Infection Prevention and Control Program designed to provide a safe and sanitary environment. Specifically, (1) The facility could not provide evidence that a facility risk assessment was conducted annually to identify where waterborne pathogens could grow and spread in the facility water system and 2) the facility did not update the Water Management Plan since July 2017. The findings are: The facility Legionella Water Management Program dated July 2017 documented the purpose of the water management program is to identify areas in the water systems where Legionella bacteria can grow and spread. 1) The facility did not provide any documented evidence that an Environmental Assessment of Water Systems in Healthcare Settings was performed and updated annually to minimize the risk of healthcare facility associated Legionella Species according to best practice standards and regulations. 2) The facility Water Management Program was last updated July 2017. During an interview with the Director of Nursing (DON) on 8/11/23 at 11:07 AM, they stated they were not involved with the Environmental Assessment and only dealt with Legionella portion if residents were having symptoms. During an interview conducted with the Director of Maintenance (DOM) on 08/14/23 at 09:27 AM, they stated that they are in charge of Legionella, but they did not have an Environmental Assessment of Water Systems in the Maintenance binder. The DOM stated they have been at the facility for four months, did not have nursing home experience and was not familiar with the Environmental Risk Assessment or Water Management Plan in place. The DOM stated that an outside vendor does the water testing / sampling and stated the last water sampling was performed on 2/16/23 and all samples were negative. During an interview with the Administrator on 8/14/23 at 2:00 PM, they stated the DOM was being trained by the DOM from a sister facility about the Water Management Plan and Environmental Assessment. The Administrator also stated they did not know the Water Management Plan needed to be updated annually but it was important that a current plan was in place to identify problems early. The Administrator stated they started at the facility November 2022 and was still getting things together. 10NYCRR 415.19

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 41666 Based on record review and interviews during a recertification survey from 8/9/23 to 8/15/23, the facility did not ensure that the Infection Preventionist (IP) completed specialized training in infection prevention and control prior to assuming the role. Specifically, the facility's designated IP who is the Director of Nursing Services (DON), did not have documented evidence of completed specialized training in infection prevention and control until 08/11/23. The findings are: During the annual survey Entrance Conference on 8/09/23 at 9:33 AM, the Director of Nursing (DON) identified themselves as the Infection Preventionist since they started at the facility in October of 2022. When asked for proof of training, they stated they could not find it. On 8/11/23 at 02:30 PM, the DON presented a document titled Training Plan Proof of Completion as of 8/11/23 and included an attached copy of course modules. One of the modules had a completion date of 8/11/23. During an interview with the DON on 8/14/23 at 10:21 AM the DON stated they have a certificate of Proof of Training effective 8/11/23 because that was the date they finished the last module and could not print a certificate until the last module was completed. The DON stated they did not realize it was incomplete all along. 10NYCRR 415.19

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on interview and record review conducted during a recertification survey from 8/9/23 to 8/15/23, the facility did not provide a COVID-19 vaccination for 1 (Resident #110) of 5 residents reviewed for COVID-19 vaccination after screening and consent was obtained. Specifically, Resident #110 had consent from 12/7/22 but had not received the vaccine when reviewed as of 8/14/23. Findings include: The facility policy titled COVID-19 Infection Control Policy, dated 2/11/2022, documented the updated COVID-19 vaccination will be offered within 14 days of admission/readmission. Resident #110 was admitted [DATE] and had diagnoses including Dysphagia, Type II Diabetes, and Depression. The Minimum Data Set (MDS, a resident assessment tool) dated 5/10/23, documented the resident had cognitive impairment, required extensive assistance with bed mobility, transfers and toilet use and received a gastrostomy tube feeding. The resident had a Consent for the COVID-19 immunization which was obtained 12/7/22. The resident's immunization record documented the resident had consent since 12/7/22 but had not received the COVID-19 vaccine as of 8/14/23. During an interview with the Director of Nursing (DON) on 8/15/23 at 8:36 AM, they stated they were responsible for making sure residents received education and were offered updated vaccines. The resident was eligible and had a consent for the COVID-19 vaccine dated 12/7/22, but the resident was in and out of the hospital and they lost track of giving the vaccine. They stated it should have been given within 2 weeks of admission to the facility. The DON stated it was their job to make sure the vaccines were offered, ordered, and given. 10NYCRR 415.19