STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335019	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regeis Care Center	3200 Baychester Avenue Bronx, NY 10475

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record reviews, and interviews, conducted during a survey, the facility failed to ensure that a resident was free from physical abuse. This was evident for one (1) out of six (6) residents (Resident #1) sampled for abuse. Specifically, on 02/17/2026 at 5:30 PM, Resident #2's visitor reported to the Director of Nursing that they observed Certified Nursing Assistant #1 rough handed and hit Resident #1 on their buttock. A review of the facility surveillance video footage dated 02/17/2026 at 4:34 PM corroborated what the visitor reported to the Director of Nursing and later reported to the New York State Department of Health. The findings are:The facility's Policy titled Abuse Prohibition Policy and Protocol dated 09/11/2025 documented Residents of facility will be protected from abuse, neglect, mistreatment, and misappropriation of property in accordance with state and federal regulations. The policy also states the facility has zero tolerance for any kind of patient abuse, neglect, or mistreatment. Resident #1 was admitted to the facility with diagnoses that included non-Alzheimer's Dementia, muscle weakness, and difficulty walking.The quarterly Minimum Data Set (a resident assessment tool) dated 01/02/2026 documented Resident #1 had severely impaired cognition. Section GG - Functional Abilities documented Resident #1 required partial/moderate assistance - helper does less than half the effort. Helper lifts, holds, or support the trunk or limbs, but provides less than half the effort.A care plan for wandering/elopement dated 01/09/2026 documented Resident #1 walking into other residents' room uninvited which put resident at risk for potential abuse. The interventions are documented to monitor Resident #1's whereabouts and redirect as needed.There was no documented evidence for frequency of monitoring.A Care plan for behavior symptoms resistive to care dated 12/15/2025 documented interventions to provide positive reinforcement for appropriate behavior, redirect resident as appropriate, maintain calm, safe environment, and address resident in a calm and gentle manner.A review of the facility surveillance video footage dated 02/17/2026 at 4:34 PM showed at 4:38 PM Resident #1 got up from their wheelchair ambulating with unsteady gait up the hallway while holding onto the handrails in the hallway. Resident #1 walked over to the other side of the hallway, where a cart stocked with personal protective equipment was, then rolled the cart into two residents' rooms. Certified Nursing Assistant #1 who was wheeling a resident up the hallway as Resident #1 entered one of the rooms with the cart, stopped and went into the room behind Resident #1. Certified Nursing Assistant rolled the cart into the hallway, and Certified Nursing Assistant #1 was seen standing in the doorway pulling Resident #1 by the arm, Certified Nursing Assistant #1 then pulled Resident #1 into the hallway. Then, Certified Nursing Assistant #1 held Resident #1 under the left armpit and pull Resident #1 up the hallway to their wheelchair as Resident #1 continued to resist. Certified Nursing Assistant #1 then put Resident #1 to sit on the edge of their wheelchair, as Resident #1 resisted sitting, Certified Nursing Assistant #1 held Resident #1 under the left armpit, putting their right hand behind Resident #1 holding them by the pants and dragged Resident #1 all the way back into the wheelchair then push and held Resident #1's upper body forward with their left hand, while their right hand moved back/forth at Resident #1's lower back, and Resident #1's body jerked forward. Resident #2's visitor observed standing in the doorway of Resident #2's room looking in the direction of Certified Nursing Assistant (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: 335019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regeis Care Center	3200 Baychester Avenue Bronx, NY 10475

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#1 and Resident #1. The family member and Certified Nursing Assistant #1 appeared to be exchanging words and hand gestures.A review of the facility Summary Investigation for Incident which occurred between Certified Nursing Assistant #1 and Resident #2's visitor on 02/17/2026 at 5:30 PM, revealed Resident #2's visitor went to the Director of Nursing office demanding Certified Nursing Assistant receive a discipline as they engaged in a verbal altercation on the unit and was disrespectful to them. The visitor also said they heard a commotion on the unit and came out of Resident #2's room to observe what was happening and asked Certified Nursing Assistant, who was attending Resident 1, what they were doing. Immediately following the meeting, the camera was reviewed, and Resident #1 was observed sitting at the nursing station in their wheelchair. Then got up and wandered into other residents' rooms and Certified Nursing Assistant #1 immediately assisted Resident #1 back into their wheelchair using compact pivot transfer to maintain safety. A review of Registered Nurse Supervisor #1 statement to the facility dated 02/17/2026 documented they were instructed (by Director of Nursing) to assessed Resident #1. They entered Resident #1's room and observed Resident #1 sitting on their bed smiling and in good spirits. They assessed Resident #1 with no visible injury. Resident #1 reported no complaints of pain or discomfort. There was no documented evidence that the alleged abuse allegation was investigated or reported to the New York State Department of Health.On 02/25/2026 at 10:02 AM, Resident #2's visitor (complainant) was interviewed and stated that on 02/17/2026 at approximately 5:30 PM, they observed Certified Nursing Assistant #1 rough handed and hit Resident #1 on their buttocks. Resident #2's visitor stated they reported the incident to the Director of Nursing who promised to look at the issue.On 02/25/2026 at 2:00 PM Certified Nursing Assistant #1 was interviewed and stated they worked on the 3:00 PM - 11:00 PM shift on 02/17/2026. Certified Nursing Assistant #1 stated they were not assigned to Resident #1, but observed Resident #1 entered another resident's room with the Personal Protective Cart on 02/17/2026 at approximately 4:39PM. Certified Nursing Assistant #1 stated they put the cart into the hallway then held Resident #1 under the armpit and escorted Resident #1 out of the other resident's room. Certified Nursing Assistant #1 stated while they were walking with Resident #1, they were resisting and making noise. Certified Nursing Assistant #1 stated they took Resident #1 to their wheelchair and sat them in the chair. Certified Nursing Assistant #1 stated while they were putting Resident #1 to sit in the wheelchair a family member (Resident #2's visitor) asked them what they were doing with Resident #1. Certified Nursing Assistant #1 stated they did not answer Resident #2's visitor and the visitor started arguing with them. Certified Nursing Assistant #1 stated they walked away and informed Licensed Practical Nurse #1. Certified Nursing Assistant #1 stated they did not roughly handle or hit Resident #1 on their buttock.On 02/26/2026 at 11:28 AM, Licensed Practical Nurse #1 was interviewed and stated on 02/17/2026 at approximately 4:40 PM Certified Nursing Assistant #1 approached them and reported that Resident #2's visitor asked them what they were doing with Resident #1 and that they did not answer because Resident #1 was not their (Resident #2 visitor) loved one. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 informed them that Resident #2's visitor was arguing with them but did not elaborate on what the argument was about. On 02/25/2026 at 3:37 PM, Registered Nurse Supervisor #1 was interviewed and stated on 02/17/2026 Fat approximately 5:30 PM the Director of Nursing came into the nursing office and reported that a family member reported Certified Nursing Assistant #1 on the 4th floor was cursing at them because they asked Certified Nursing Assistant #1 what they were doing with Resident #1. Registered Nurse Supervisor #1 stated that the Director of Nursing reported to them that they reviewed the surveillance video footage and observed Certified Nursing Assistant #1 attempting to put Resident #1 into their wheelchair. Registered Nurse Supervisor #1 stated that the Director of Nursing instructed them to conduct a body assessment on Resident #1 and they both went to the unit and performed a body assessment on Resident #1. Registered Nurse Supervisor #1 stated the assessment revealed no redness, discoloration or visible injury. Registered Nurse Supervisor #1 stated they did not document their assessment in Resident #1's chart and did not notify the medical (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regeis Care Center	3200 Baychester Avenue Bronx, NY 10475

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	doctor.On 02/25/2026 at 1:23 PM, the Director of Nursing was interviewed and stated Resident #2's visitor did not report to them that they observed Certified Nursing Assistant #1 rough handled and hit Resident #1 on their buttocks. The Director of Nursing stated that Resident #2's visitor reported Certified Nursing Assistant #1 was rude to them. The Director of Nursing stated they reviewed the video footage to see the interaction between Certified Nursing Assistant #1 and the visitor. They did not identify the actions of Certified Nursing Assistant #1 as being abusive or excessively rough with Resident #1. Therefore, they did not further investigate the matter but suspended Certified Nursing Assistant #1 for one (1) day (02/18/2026) due to poor customer service. The Director of Nursing stated them and Registered Nurse Supervisor #1 performed a body assessment and there were no redness, discoloration or visible injuries. The Director of Nursing stated upon Certified Nursing Assistant #1's return to work, they were assigned to another unit to prevent interaction with Resident #2's visitor. On 02/25/2026 at 4:00 PM, the Assistant Administrator was interviewed and stated they reviewed the surveillance video footage and there was no harm to Resident #1. The Assistant Administrator stated they decided to suspend Certified Nursing Assistant #1 (one day) for poor customer service and removed them from the unit (Resident #1's unit). The Assistant Administrator stated there were no allegations of rough handling or hitting. Therefore, the allegation of abuse was not investigated or reported to the Department of Health.On 02/27/2026 at 12:30 PM, Medical Doctor #1 was interviewed and stated they were not aware of any allegation of rough handling or abuse involving Resident #1 on 02/17/2026. Medical Doctor #1 stated they were not in the facility when they were informed of the alleged allegation on 02/26/2026.10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Regeis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Baychester Avenue Bronx, NY 10475	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure that all alleged violations involving abuse, exploitation, or mistreatment, including injuries of unknown source are reported immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. This was evident for one (1) out of six (6) residents (Resident #1) reviewed for abuse. Specifically, on 02/17/2026 at 5:30 PM, Resident #2's visitor reported to the Director of Nursing that they observed Certified Nursing Assistant #1 rough handed and hit Resident #1 on their buttock. The facility did not report the alleged allegation of abuse to New York State Department of Health.The findings include:The facility's Policy titled ?Abuse Prohibition' last revised on 09/11/2025 documented Residents of facility will be protected from abuse, neglect, mistreatment, and misappropriation of property in accordance with state and federal regulations. It was also documented that the facility would report all alleged violations and all substantiated incidents to the New York State Department of Health and to all other agencies as required and take all necessary corrective action depending on the results of the investigation. The policy also documented that all alleged violations involving abuse neglect, exploitation, or resident's property, are reported immediately, but not later than 2hours after the allegation is made.Resident #1 was admitted to the facility with diagnoses that included non-Alzheimer's Dementia, muscle weakness, and difficulty walking.The Minimum Data Set (a resident assessment tool) dated 01/02/2025 documented Resident #1 had severely impaired cognition.A review of the facility surveillance video footage dated 02/17/2026 at 4:34 PM showed at 4:38 PM Resident #1 got up from their wheelchair ambulating with unsteady gait up the hallway while holding onto the handrails in the hallway. Resident #1 walked over to the other side of the hallway, where a cart stocked with personal protective equipment was, then rolled the cart into two residents' rooms. Certified Nursing Assistant #1 who was wheeling a resident up the hallway as Resident #1 entered one of the rooms with the cart, stopped and went into the room behind Resident #1. Certified Nursing Assistant rolled the cart into the hallway, and Certified Nursing Assistant #1 was seen standing in the doorway pulling Resident #1 by the arm, Certified Nursing Assistant #1 then pulled Resident #1 into the hallway. Then, Certified Nursing Assistant #1 held Resident #1 under the left armpit and pull Resident #1 up the hallway to their wheelchair as Resident #1 continued to resist. Certified Nursing Assistant #1 then put Resident #1 to sit on the edge of their wheelchair, as Resident #1 resisted sitting, Certified Nursing Assistant #1 held Resident #1 under the left armpit, putting their right hand behind Resident #1 holding them by the pants and dragged Resident #1 all the way back into the wheelchair then push and held Resident #1's upper body forward with their left hand, while their right hand moved back/forth at Resident #1's lower back, and Resident #1's body jerked forward. Resident #2's visitor observed standing in the doorway of Resident #2's room looking in the direction of Certified Nursing Assistant #1 and Resident #1. The family member and Certified Nursing Assistant #1 appeared to be exchanging words and hand gestures.A review of the facility Summary Investigation for Incident which occurred between Certified Nursing Assistant #1 and Resident #2's visitor on 02/17/2026 at 5:30 PM, revealed Resident #2's visitor went to the Director of Nursing office demanding Certified Nursing Assistant #1 receive a discipline as they engaged in a verbal altercation on the unit and was disrespectful to them. The visitor also said they heard a commotion on the unit and came out of Resident #2's room to observe what was happening and asked Certified Nursing Assistant #1, who was attending Resident 1, what they were doing. Immediately following the (continued on next page)

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	335019	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regeis Care Center	3200 Baychester Avenue Bronx, NY 10475

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	meeting, the camera was reviewed, and Resident #1 was observed sitting at the nursing station in their wheelchair. Resident #1 then got up and wandered into other residents' rooms and Certified Nursing Assistant #1 immediately assisted Resident #1 back into their wheelchair using compact pivot transfer to maintain safety. A review of Registered Nurse Supervisor #1 statement to the facility dated 02/17/2026 documented they were instructed (by Director of Nursing) to assessed Resident #1. They entered Resident #1's room and observed Resident #1 sitting on their bed smiling and in good spirits. They assessed Resident #1 with no visible injury. Resident #1 reported no complaints of pain or discomfort. There was no documented evidence that the alleged abuse was reported to New York State Department of Health.On 02/25/2026 at 4:00 PM, the Assistant Administrator was interviewed and stated they reviewed the surveillance video footage and there was no harm to Resident #1. The Assistant Administrator stated they decided to suspend Certified Nursing Assistant #1 (one day) for poor customer service and removed them from the unit (Resident #1's unit). The Assistant Administrator stated there were no allegations of rough handling or hitting. Therefore, the allegation of abuse was not investigated or reported to the Department of Health. On 02/27/2026 at 12:30 PM, Medical Doctor #1 was interviewed and stated they were not aware of any allegation of rough handling or abuse involving Resident #1 on 02/17/2026. 10 New York Codes, Rules, and Regulations 415.4(b)(2)

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Regeis Care Center	3200 Baychester Avenue Bronx, NY 10475

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure that allegations of abuse were investigated thoroughly and that residents were protected from further abuse during the investigation. This was evident for one (1) out of six (6) residents (Resident #1) reviewed for abuse. Specifically, on 02/17/2026 at 5:30 PM, Resident #2's visitor reported to the Director of Nursing that they observed Certified Nursing Assistant #1 roughly handle and hit Resident #1 on the buttock. The Director of Nursing failed to thoroughly investigate the allegation of abuse and remove Certified Nurse Assistant #1 from direct care and access to residents after allegations were reported. This resulted in Immediate Jeopardy and Substandard Quality of Care with the likelihood of serious harm to 222 residents.The findings include:The facility's policy and procedure title Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property last revised on 09/11/2025, documented Residents of the facility will be protected from abuse, neglect, mistreatment, and misappropriation of property in accordance with State and Federal regulations. The policy also documented all alleged or suspected incidents of abuse, neglect, mistreatment or misappropriation of resident's property will be thoroughly investigated and findings documented and reported.Resident #1 was admitted to the facility with diagnoses that included non-Alzheimer's dementia, muscle weakness, and difficulty walking.The Minimum Data Set (a resident assessment tool) dated 01/02/2025 documented Resident #1 had severely impaired cognition.A review of the facility surveillance video footage from unit four (4) dated 02/17/2026 at 4:34 PM showed at 4:38 PM, Resident #1 got up from their wheelchair ambulating with unsteady gait up the hallway while holding onto the handrails in the hallway. Resident #1 walked over to the other side of the hallway, where a cart stocked with personal protective equipment was, then rolled the cart into two residents' rooms. Certified Nursing Assistant #1, who was wheeling a resident up the hallway as Resident #1 entered one of the rooms with the cart, stopped and went into the room behind Resident #1. Certified Nursing Assistant #1 rolled the cart into the hallway, and Certified Nursing Assistant #1 was seen standing in the doorway pulling Resident #1 by the arm. Certified Nursing Assistant #1 then pulled Resident #1 into the hallway. Certified Nursing Assistant #1 held Resident #1 under the left armpit and pulled Resident #1 up the hallway to their wheelchair as Resident #1 continued to resist. Certified Nursing Assistant #1 then put Resident #1 to sit on the edge of their wheelchair, as Resident #1 resisted sitting, Certified Nursing Assistant #1 held Resident #1 under the armpit and pants and dragged Resident #1 all the way back into the wheelchair. Certified Nursing Assistant #1 pushed Resident #1's upper body forward while their right hand moved back/forth at Resident #1's lower back (appeared to hit Resident #1 on the buttock) and Resident #1's body jerked forward. Resident #2's visitor (the complainant) observed standing in the doorway of Resident #2's room looking in the direction of Certified Nursing Assistant #1 and Resident #1. The family member and Certified Nursing Assistant #1 appeared to be exchanging words and hand gestures.A review of the undated facility Summary Investigation for Incident which occurred between Certified Nursing Assistant #1 and Resident #2's visitor on 02/17/2026 at 5:30 PM, revealed Resident #2's visitor went to the Director of Nursing office demanding Certified Nursing Assistant #1 receive a discipline as they engaged in a verbal altercation on the unit and were disrespectful to them. The visitor also said they heard a commotion on the unit and came out of Resident #2's room to observe what was happening and asked Certified Nursing Assistant #1, who was attending Resident 1, what they were doing. Immediately following the meeting, the camera was reviewed, and Resident #1 was observed sitting at the nursing station in their wheelchair. Resident #1 then got up and wandered into other residents' rooms and Certified Nursing Assistant #1 immediately assisted Resident #1 back into their wheelchair using compact pivot transfer to maintain safety. A review of Registered Nurse Supervisor #1's statement to the facility dated 02/17/2026 documented they were instructed (by Director of Nursing) to assess Resident #1. They entered Resident #1's room and observed Resident #1 sitting on their bed smiling (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	and in good spirits. They assessed Resident #1 with no visible injury. Resident #1 reported no complaints of pain or discomfort. There was no documented evidence of a registered nurse assessment for Resident #1.The New York State Department of Health Surveyor went onsite on 02/25/2026 and the facility initiated the investigation into the abuse allegation on 02/27/2026. A review of Certified Nursing Assistant #1's Employee Attendance sheet dated 01/01/2026 - 02/27/2026 revealed Certified Nursing Assistant #1 last worked on 02/20/2026 and 02/21/2026 (on the evening shift).A review of the unit Staffing Sheet dated 02/20/2026 revealed Certified Nursing Assistant #1 worked on the second floor on the evening shift and worked on 02/21/2026 on the third floor on the evening shift. On 02/25/2026 at 10:02 AM, Resident #2's visitor (complainant) was interviewed and stated that on 02/17/2026 at approximately 5:30 PM, they observed Certified Nursing Assistant #1 roughly handle and hit Resident #1 on their buttocks. Resident #2's visitor stated they reported the incident to the Director of Nursing who promised to look at the issue.On 02/25/2026 at 1:23 PM, the Director of Nursing was interviewed and stated Resident #2's visitor did not report to them that they observed Certified Nurse Assistant #1 roughly handle and hit Resident #1 on their buttocks. The Director of Nursing stated that the visitor reported Certified Nursing Assistant #1 was rude to them. The Director of Nursing stated they reviewed the video footage to see the interaction between Certified Nursing Assistant #1 and the visitor. The Director of Nursing stated they did not identify the actions of Certified Nursing Assistant #1 to be abusive or excessively rough with Resident #1. The Director of Nursing stated Certified Nursing Assistant #1 denied the abuse allegations. Therefore, they did not further investigate the matter but suspended Certified Nursing Assistant #1 for one (1) day (02/18/2026) due to poor customer service. The Director of Nursing stated when Certified Nursing Assistant #1 returned from suspension, they were assigned to another unit to prevent interaction with Resident #2's visitor. On 02/25/2026 at 3:37 PM, Registered Nurse Supervisor #1 was interviewed and stated on 02/17/2026 at approximately 5:30 PM, the Director of Nursing came into the nursing office and reported that a family member reported Certified Nursing Assistant #1 on the fourth floor was cursing at them because they asked Certified Nursing Assistant #1 what they were doing with Resident #1. Registered Nurse Supervisor #1 stated that the Director of Nursing reported to them that they reviewed the surveillance video footage and observed Certified Nursing Assistant #1 attempting to put Resident #1 into their wheelchair. Registered Nurse Supervisor #1 stated that the Director of Nursing instructed them to conduct a body assessment on Resident #1. Registered Nurse Supervisor #1 stated they and the Director of Nursing went to the unit and performed a body assessment on Resident #1. Registered Nurse Supervisor #1 stated the assessment revealed no redness, discoloration or visible injury. Registered Nurse Supervisor #1 stated they did not document their assessment in Resident #1's chart and did not notify the medical doctor.On 02/25/2026 at 4:00 PM, the Assistant Administrator was interviewed and stated they reviewed the surveillance video footage and there was no harm to Resident #1. The Assistant Administrator stated they decided to suspend Certified Nursing Assistant #1 for poor customer service and removed them from the unit (Resident #1's unit). The Assistant Administrator stated there were no allegations of rough handling or hitting.On 02/27/2026 at 12:30 PM, Medical Doctor #1 was interviewed and stated they were not aware of any allegation of rough handling or abuse involving Resident #1 on 02/17/2026. Medical Doctor #1 stated they were not in the facility when they were informed of the alleged allegation on 02/26/2026.Immediate Jeopardy was identified, and the Administrator and the Director of Nursing were notified on 03/02/2026 at 2:15 PM. An acceptable immediate corrective action plan from the facility was received on 03/03/2026 at 10:25 AM.Immediate Jeopardy was removed prior to the survey exit of 03/04/2026 based on the following corrective actions taken by the facility:1. Certified Nursing Assistant #1 was removed on 02/25/2026.2. Resident #1 was assessed on 02/25/2026.3. Facility wide in-service conducted on 02/25/2026.4. Administration rounding on all units conducted 02/25/2026.5. Resident #1's care plan was reviewed and updated 02/25/2026.6. Audit log dated 02/25/2026 for Accident/Incidents reviewed for past 30 days.7. Facility reviewed and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Regeis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Baychester Avenue Bronx, NY 10475	

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	assessed 52 residents for abuse and mistreatment.8. Nurse Practitioner assessed Resident #1 on 02/26/2026.9. The Director of Nursing and Assistant Director of Nursing received in-service on 03/02/2026. Lesson Plan F610 - ensuring a thorough investigation of all allegations.10. Interdisciplinary Meeting held on 02/27/202611. Facility investigation dated 02/27/2026 reviewed12. Facility reviewed Policy and Procedure on Abuse Prevention on 03/02/2026 10 New York Codes, Rules, and Regulations 415.4(b)(3)

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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 Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents. Specifically, Resident #1 who has unsteady gait and was at risk for fall, was seen on the facility's surveillance video footage on 02/17/2026 ambulating in the hallway without assistance. Resident #1 walked over to the other side of the hallway, where a cart stocked with personal protective equipment was, then rolled the cart into two residents' rooms. The findings are:The facility's Policy titled Incident/Accident Prevention Program dated 02/09/2026 states it is the policy of the facility to monitor and evaluate any adverse occurrence which is not consistent with the routine operation of the facility or care of a resident(s). All accidents/incidents where there are mistreatment, neglect, abuse, or injuries of unknown origin will be reported to the Director of Nursing/Designee and Administrator/Designee immediately for further review and reporting based on State and Federal regulations.Resident #1 was admitted to the facility with diagnoses that included non-Alzheimer's Dementia, muscle weakness, and difficulty walking.The quarterly Minimum Data Set (a resident assessment tool) dated 01/02/2026 documented Resident #1 had severely impaired cognition. Section GG - Functional Abilities (walk 50 feet) documented Resident #1 required partial/moderate assistance - helper does less than half the effort. Helper lifts, holds, or support the trunk or limbs, but provides less than half the effort. Section GG also documented Resident #1 required partial/moderate assistance from a sitting in a chair to a standing position. Resident #1 uses a wheelchair for locomotion.A review of the Fall Care Plan last reviewed on 01/05/2026 documented interventions to keep room and hallways well-lit, clean, and clutter free, call bell within easy reach, encourage and remind residents to call for assistance, properly fitted footwear, gripper socks at night and to provide assistance with activities of daily living care as needed. Floors are dry and clean.A review of the facility surveillance video footage from unit four (4) dated 02/17/2026 at 4:34 PM showed at 4:38 PM Resident #1 got up from their wheelchair ambulating with unsteady gait up the hallway while holding onto the handrails in the hallway. Resident #1 walked over to the other side of the hallway, where a cart stocked with personal protective equipment was, then rolled the cart into two residents' rooms. Certified Nursing Assistant #1 who was wheeling a resident up the hallway as Resident #1 entered one of the rooms with the cart, stopped and went into the room behind Resident #1. Certified Nursing Assistant #1 rolled the cart into the hallway, and Certified Nursing Assistant #1 was seen standing in the doorway pulling Resident #1 by the arm. Certified Nursing Assistant #1 then pulled Resident #1 into the hallway. Certified Nursing Assistant #1 held Resident #1 under the left armpit and pulled Resident #1 up the hallway to their wheelchair as Resident #1 continued to resist. Certified Nursing Assistant #1 then put Resident #1 to sit on the edge of their wheelchair, as Resident #1 resisted sitting, Certified Nursing Assistant #1 held Resident #1 under the armpit and pants and dragged Resident #1 all the way back into the wheelchair. Certified Nursing Assistant #1 pushed Resident #1's upper body forward while their right hand moved back/forth at Resident #1's lower back (appeared to hit Resident #1 on the buttock) and Resident #1's body jerked forward.On 02/25/2026 at 2:00 PM, Certified Nursing Assistant #1 was interviewed and stated they worked on Resident #1's unit on the 3:00 PM - 11:00 PM shift on 02/17/2026. Certified Nursing Assistant #1 stated there were three (3) Certified Nursing Assistants and one (1) Licensed Practical Nurse on the Southeast (Resident #1's side of the unit) side of the unit. Certified Nursing Assistant #1 stated that one (1) Certified Nursing Assistant was monitoring residents in the dining room while another Certified Nursing Assistant took residents to their room and provided incontinent care before taking them to the dining room for dinner. Certified Nursing Assistant #1 stated while they were going in and out of residents' rooms, they were also keeping an eye on the other residents sitting in the hallway. Certified Nursing Assistant #1 stated that Licensed Practical Nurse #1 was also keeping an eye on the residents while they were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Regeis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Baychester Avenue Bronx, NY 10475	

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 Note: The nursing home is disputing this citation.	administering medications. Certified Nursing Assistant #1 further stated they Resident #1 was not assigned to them, but they were aware Resident #1 was at risk for fall so when they saw Resident #1 ambulating in the hallway, they immediately stopped and escorted the resident back to their wheelchair.On 02/26/2026 at 1:30 PM, Certified Nursing Assistant #2 was interviewed and stated they were assigned to Resident #1 on 02/17/2026 on the 3:00 PM to 11:00 PM shift. Certified Nursing Assistant #2 started at approximately 4:45 PM after completing care for another resident, Certified Nursing Assistant #1 came into the room and informed them Resident #1 was misbehaving at the nursing station (standing up and walking into rooms) and that Resident #1 needed to change. Certified Nursing Assistant #2 stated they took Resident #1 into their room and performed incontinent care then transported Resident 1 to the dining room for dinner. Certified Nursing Assistant #2 stated all staff on the unit are supposed to monitor the residents and that Resident #1 was on hourly visual monitoring.On 02/26/2026 at 11:28 AM, Licensed Practical Nurse #1 was interviewed and started on 02/17/2026 at approximately 4:34 PM they were on Resident #1's unit administering medications and were going in and out of residents' rooms as they monitored the residents who were sitting in the hallway. Licensed Practical Nurse #1 also stated that the Certified Nursing Assistants were transporting residents to their room to provide incontinent care before dining (dinner time between 5:00 PM and 5:30 PM). On 02/25/2026 at 3:37 PM, Registered Nurse Supervisor #1 was interviewed and stated that Licensed Practical Nurse #1 is responsible for ensuring the Certified Nursing Assistants are monitoring all the residents on the unit. Registered Nurse Supervisor #1 stated they performed rounds on the unit at 4:15 PM on 02/17/2026 and the residents were in the dining room being monitored by a Certified Nursing Assistant.On 02/25/2026 at 1:23 PM, the Director of Nursing was interviewed and stated on 02/17/2026 they reviewed the surveillance video record which showed Resident#1 got up out of their wheelchair and was walking in the hallway and staff members were going in and out of residents' rooms. The Director of Nursing stated that the staff were also monitoring the three (3) residents who were sitting in the hallway. 10 New York Codes, Rules, and Regulations 415.12(h)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regeis Care Center	3200 Baychester Avenue Bronx, NY 10475

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure the facility was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was evident in one (1) out of six (6) residents sampled (Resident #1). Specifically, on 02/17/2026 at 5:30 PM, Resident #2's visitor reported to the Director of Nursing that they observed Certified Nursing Assistant #1 abused Resident #1. The facility surveillance video footage dated 02/17/2026 at 4:34 PM corroborated what the visitor reported to the Director of Nursing and later reported to the New York State Department of Health. Facility administration did not immediately investigate the alleged abuse and protect residents from further potential abuse. Additionally, the facility did not report the alleged allegation of abuse to the New York State Department of Health within 2 hours after the allegation was made.The findings are:The facility's Policy and Procedure entitled, Administration-Management with revision date 10/14/2024 documented the facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.Resident #1 was admitted to the facility with diagnoses that included non-Alzheimer's Dementia, muscle weakness, and difficulty walking.The Minimum Data Set (a resident assessment tool) dated 01/02/2025 documented Resident #1 had severely impaired cognition.A review of the facility surveillance video footage from unit 4 dated 02/17/2026 at 4:34 PM showed at 4:38 PM Resident #1 got up from their wheelchair ambulating with unsteady gait up the hallway while holding onto the handrails in the hallway. Resident #1 walked over to the other side of the hallway, where a cart stocked with personal protective equipment was, then rolled the cart into two residents' rooms. Certified Nursing Assistant #1 who was wheeling a resident up the hallway as Resident #1 entered one of the rooms with the cart, stopped and went into the room behind Resident #1. Certified Nursing Assistant rolled the cart into the hallway, and Certified Nursing Assistant #1 was seen standing in the doorway pulling Resident #1 by the arm, Certified Nursing Assistant #1 then pulled Resident #1 into the hallway. Then, Certified Nursing Assistant #1 held Resident #1 under the left armpit and pull Resident #1 up the hallway to their wheelchair as Resident #1 continued to resist. Certified Nursing Assistant #1 then put Resident #1 to sit on the edge of their wheelchair, as Resident #1 resisted sitting, Certified Nursing Assistant #1 held Resident #1 under the left armpit, putting their right hand behind Resident #1 holding them by the pants and dragged Resident #1 all the way back into the wheelchair then push and held Resident #1's upper body forward with their left hand, while their right hand moved back/forth at Resident #1's lower back, and Resident #1's body jerked forward. Resident #2's visitor observed standing in the doorway of Resident #2's room looking in the direction of Certified Nursing Assistant #1 and Resident #1. The family member and Certified Nursing Assistant #1 appeared to be exchanging words and hand gestures.A review of the facility Summary Investigation for Incident which occurred between Certified Nursing Assistant #1 and Resident #2's visitor on 02/17/2026 at 5:30 PM, revealed Resident #2's visitor went to the Director of Nursing office demanding Certified Nursing Assistant #1 receive a discipline as they engaged in a verbal altercation on the unit and was disrespectful to them. The visitor also said they heard a commotion on the unit and came out of Resident #2's room to observe what was happening and asked Certified Nursing Assistant #1, who was attending Resident 1, what they were doing. Immediately following the meeting, the camera was reviewed, and Resident #1 was observed sitting at the nursing station in their wheelchair. Resident #1 then got up and wandered into other residents' rooms and Certified Nursing Assistant #1 immediately assisted Resident #1 back into their wheelchair using compact pivot transfer to maintain safety. A review of Registered Nurse Supervisor #1 statement to the facility dated 02/17/2026 documented they were instructed (by Director of Nursing) to assess Resident #1. They entered Resident #1's room and observed Resident #1 sitting on their bed smiling and in good (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Regeis Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Baychester Avenue Bronx, NY 10475	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	spirits. They assessed Resident #1 with no visible injury. Resident #1 reported no complaints of pain or discomfort. The New York State Department of Health Surveyor went onsite on 02/25/2026 and the facility initiated the investigation into the abuse allegation on 02/27/2026. A review of Certified Nursing Assistant #1's Employee Attendance sheet dated 01/01/2026 - 02/27/2026 showed Certified Nursing Assistant #1 lasted worked on 02/20/2026 and 02/21/2026.A review of the facility Staffing Sheet for the 3:00 PM - 11:00 PM shift revealed Certified Nursing Assistant #1 worked on 02/20/2026 and 02/21/2026 on the second and third floor. On 02/25/2026 at 1:23 PM, the Director of Nursing was interviewed and stated Resident #2's visitor did not report to them that they observed Certified Nurse Assistant #1 rough handled and hit Resident #1 on their buttocks. The Director of Nursing stated that the visitor reported Certified Nursing Assistant #1 was rude to them. The Director of Nursing stated they reviewed the video footage to see the interaction between Certified Nursing Assistant #1 and the visitor. The Director of Nursing stated they did not identify the actions of Certified Nursing Assistant #1 to be abusive or excessively rough with Resident #1. The Director of Nursing stated Certified Nursing Assistant #1 denied the abuse allegations. Therefore, they did not further investigate the matter but suspended Certified Nursing Assistant #1 for one (1) day (02/18/2026) due to poor customer service. The Director of Nursing stated when Certified Nursing Assistant #1 returned from suspension, they were assigned to another unit to prevent interaction with Resident #2's visitor. On 02/25/2026 at 4:00 PM, the Assistant Administrator was interviewed and stated they reviewed the surveillance video footage and there was no harm to Resident #1. The Assistant Administrator stated they decided to suspend Certified Nursing Assistant #1 (one day) for poor customer service and removed them from the unit (Resident #1's unit). The Assistant Administrator stated there were no allegations of rough handling or hitting. Therefore, the allegation of abuse was not investigated or reported to the Department of Health. 10 New York Codes, Rules, and Regulations 415.26