STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335061	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Center for Rehabilitation and Nursing	2505 Grand Avenue Bronx, NY 10468

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility did not ensure that assessments accurately reflected the residents' status. This was evident for one (1) of one (1) resident (Resident #3) reviewed for Respiratory Care out of forty-six (46) sampled residents. Specifically, The Minimum Data Set 3.0 (MDS) assessment did not document Resident #3 was in use of continuous oxygen. The findings are: Resident #3 had diagnoses upon admission that included Non-Alzheimer's Dementia, Deep venous thrombosis (DVT), and bipolar disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented that the resident's cognitive status was severely impaired. The Minimum Data Set assessment did not document that the resident was use of continuous oxygen at the time of assessment.ˆ The Physician's order, dated 11/12/2025 and renewed 03/01/2026, documented the following: Oxygen via nasal cannula at two (2) liters per minute. Monitor oxygen every shift. Nursing Quarterly Care Plan Note, dated 01/28/2026, documented that Resident #3ˆis on continuous oxygen. Resident's needs are met and safety maintained. Will continue plan of care through next period. On 03/24/2026 at 02:12 PM, an interview was conducted with the Minimum Data Set Coordinator who stated that they perform a physical assessment and review medical records prior to completing the Minimum Data Set assessment. They also stated that the use of continuous oxygen should be coded on the Minimum Data Set assessment but could not explain why the use of continuous oxygen for Resident #3 was not captured on their Quarterly Minimum Data Set assessment. They concluded that it was oversight. 10 New York Code Rules and Regulations 415.11 (b)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335061	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Center for Rehabilitation and Nursing	2505 Grand Avenue Bronx, NY 10468

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure that residents received necessary respiratory care consistent with professional standards of practice and the comprehensive care plan. This was evident for one (1) of one (1) resident (Resident #3) reviewed for Respiratory Care out of forty-six (46) sampled residents. Specifically, Resident #3 was observed receiving oxygen via nasal cannula at a rate of four (4) liters per minute when the Physician's Order was written for oxygen to be received at a rate of two (2) liters per minute. The findings are: The facility's policy titled, Oxygen Therapy Administration, last reviewed 09/17/2025, documented to initiate flow of oxygen following manufacturer instructions for use, based on the type of device, and at the prescribed flow rate. The facility's Oxygen Therapy Administration policy did not include how oxygen therapy is to be monitored. Resident #3 had diagnoses upon admission that included Non-Alzheimer's Dementia, Deep venous thrombosis (DVT), bipolar disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented that the resident's cognitive status was severely impaired. The Minimum Data Set assessment also documented that the resident was not in use of continuous oxygen at the time of assessment. ˆ On 03/19/2026 at 12:14 PM, Resident #3 was observed sitting on the chair in the day room. ˆThe resident was receiving 4 liters per minute via nasal cannula from an oxygen concentrator. License Practical Nurse #1 was also present at the time of this observation. The Physician's order, dated 11/12/2025 and renewed 03/01/2026, documented the following: Oxygen via nasal cannula at two (2) liters per minute. Monitor oxygen every shift. The Nursing Quarterly Care Plan Note, dated 01/28/2026, documented that Resident #3ˆis on continuous oxygen. Resident's needs are met and safety maintained. Will continue plan of care through next period. The review of Resident #3's comprehensive care plan for Respiratory Care, initiated on 08/01/2025 and last revised on 01/28/2026, documented that the resident was at risk for respiratory distress related to disease process. Interventions include provide oxygen per physician orders and maintain or change tubing per protocol. A review of the medical record was conducted on 03/19/2026, and the medical record failed to evidence documentation of oxygen saturation monitoring. On 03/19/2026 at 1:15 PM, an interview was conducted with Licensed Practical Nurse #1 who had adjusted the rate of oxygen after observing Resident #3 with the surveyor stated the rate of 4 liters per minute was an error. Licensed Practical Nurse #1 stated that they adjusted the oxygen to 2 liters per minute as per the physician order. Licensed Practical Nurse #1 could not state how or who adjusted the oxygen to 4 liters per minute. Licensed Practical Nurse #1 stated that they ensure that resident is receiving oxygen at all times, but they also admitted there was no order to monitor oxygen saturation. On 03/23/2026 at 12:18 PM, an interview was conducted with Certified Nurse Assistant #1, assigned to Resident #3, who stated that the resident is confused, cannot make needs known and needs total care. ˆCertified Nurse Assistant #1 also stated that they were never trained to adjust the oxygen flow rate or to monitor the oxygen saturation, and therefore it was not their responsibility to check if the resident was receiving the correct amount of oxygen or achieving goal oxygen saturation. The Certified Nurse Assistant #1 stated that they ensure correct placement of the nasal cannula during care. On 03/23/26 at 12:33 PM, an interview was conducted with Registered Nurse #1 who stated that the residents are confused and cannot do anything for themselves. They stated that the resident is total care. Registered Nurse #1 also stated that medication nurses are to ensure residents receive the proper oxygen floor rates. Registered Nurse #1 further stated that the certified nurses are not trained to adjust the oxygen flow rate however they are to ensure the tube in place. Registered Nurse #1 concluded that they could not figure out why and how the oxygen flow rate for Resident #3 was adjusted to four (4) liters per minute. Registered Nurse #1 also admitted there was no order to monitor oxygen saturation. On 3/23/2026 at 1:45 PM, the Director of Nursing was interviewed and stated that if a resident requires any oxygen, there should be an oxygen saturation order in place to monitor the efficacy of oxygen (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335061	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Center for Rehabilitation and Nursing	2505 Grand Avenue Bronx, NY 10468

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy. TheˆDirector of Nursing also stated the medication nurses were to monitor the placement of the nasal cannula. The Director of Nursing noted that there was no documentation of oxygen saturation levels in the medical record for Resident #3. They stated that the resident used to have oxygen saturation monitoring every shift, but that the order had dropped off because it was placed only for 7 days. Director of Nursing could not explain why they physician had not reordered oxygen saturation monitoring. 10 New York Code Rules and Regulations 415.12(k)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335061	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Center for Rehabilitation and Nursing	2505 Grand Avenue Bronx, NY 10468

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility did not ensure that the resident medical records were accurately documented in accordance with professional standards of practice. This was evident for one (1) of three (3) residents (Resident #50) reviewed for Closed Records out of forty-six (46) total sampled residents. Specifically, Resident #50 was discharged to the hospital on [DATE], but the resident's medical record revealed that the resident was seen on 03/12/2026 and 03/19/2026 by behavioral health staff despite not having returned to the facility. The findings are: Resident #50 was admitted to the facility with diagnoses that included non-Alzheimer's dementia, depression, heart failure, and diabetes mellitus. The Minimum Data Set assessment dated [DATE] documented Resident #50 had impaired cognition. The Minimum Data Set assessment also documented that the resident requires partial/moderate assistance for upper body dressing, personal hygiene and was dependent on lower body dressing, and putting on footwear. The nurse's note dated 02/07/2026 documented that Resident #50 was reported to have increased shortness of breath and labored breathing. The Nurse Practitioner was notified and instructed staff to transfer the resident to the hospital emergency department. Resident #50 left the facility at 5:30 PM. The behavioral health note dated 03/12/2026 documented that the resident was alert and orientated to person, place, time, and situation. Behavioral health note also documented that the resident displayed a stable affect and reported euthymic mood. Thought processes were logical and organized, and resident denied any psychotic symptoms during the session, the patient appeared generally coherent and was able to engage in conversation, respond to questions, and express thoughts and feelings. Resident #50 will continue to receive psychological services. The behavioral health note dated 03/19/2026 also documented that they had an encounter with Resident #50 from 12:04 PM to12:20 PM. A review of medical record conducted on 03/25/26 revealed Resident #50 never returned to the facility after they were sent to the hospital on [DATE]. On 03/25/26 at 1:49 PM, an interview was conducted with the Licensed Mental Health Counselor, who stated that they conduct physical behavioral assessments with residents in person in several nursing homes, including University Center for Rehabilitation and Nursing. The Licensed Mental Health Counselor also stated that they have not seen Resident #50 at the University Center for Rehabilitation and Nursing, however, have seen Resident #50 in person twice at their sister facility, Williamsbridge Center for Rehabilitation and Nursing. The Licensed Mental Health Counselor concluded by saying they could not explain why their documentation appeared in the resident's medical record at University Center for Rehabilitation and Nursing. On 03/25/26 at 02:04 PM, an interview was conducted with the Behavioral Health Regional Manager who stated they oversee the behavioral health program in several nursing homes, attending to the psychological health to residents. The Behavioral Health Regional Manager also stated that Resident #50 never returned to University Center for Rehabilitation and Nursing after 02/07/2026 but was re-admitted to Williamsbridge Center for Rehabilitation and Nursing. The Behavioral Health Regional Manager further stated that they are currently looking into what happened and concluded it could be a computer issue and they would investigate it further. On 03/25/26 at 02: 15 PM, an interview was conducted with the Director of Nursing who stated that the resident was sent to the hospital on [DATE] and never came back. The Director of Nursing also stated that they were never aware that the behavioral health staff continued to document on Resident #50's medical record after the resident was discharged . The Director of Nursing could not explain why documentation from Williamsbridge Center for Rehabilitation and Nursing would be reflected on their medical records at University Center for Rehabilitation and Nursing. 10 New York Code Rules and Regulations 415.22(a)(1-4)