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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335159 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/20/2026 |
| NAME OF PROVIDER OR SUPPLIER Ross Center for Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 839 Suffolk Avenue Brentwood, NY 11717 | |

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) |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review (Incident # 2677700), the facility did not ensure each covered individual report immediately, but not later than two (2) hours, to the administration of the facility and to the New York State Department of Health after the allegation was made. This was identified for one (1) (Resident #116) of two (2) residents reviewed for Abuse. Specifically, on 11/23/2025 at 2:00 AM, Resident #116 reported a verbal abuse allegation to Licensed Practical Nurse #5. Registered Nurse #2 was made aware of the abuse allegation and did not report the incident to the facility administration until 11/24/2025, 24 hours after the allegation was made. The finding is: The facility's policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident's Property, last reviewed 06/22/2018, documented verbal abuse as any use of oral, gestured or written languages which uses degrading or derogatory terms towards residents. Mental abuse is defined as but not limited to harassment which was threats of punishment, mental anguish or mental illness. Section six (6) of the policy on reporting documented that the Director of Nursing Services or designee is responsible for reporting all alleged violations and all substantiated incident to the New York State Department of Health and to all other agencies as required. The policy did not indicate specific timeframes to for all reportable incidents including but not limited to allegation of abuse, suspicion of crime, and serious/non serious injuries. Resident #116 was admitted with diagnoses that included fracture of the left ulna (one of two long bones in the forearm), fracture of the left humerus (one of two long bones in the forearm) and multiple fractures of the ribs (curved bones that round from the back to the chest). The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, which indicated the resident had intact cognition. The resident exhibited no behavioral symptoms at the time of the assessment. The Comprehensive Care Plan for Abuse dated 11/17/2025 documented Resident #116 was at risk for abuse and neglect. Interventions included to observe resident for unusual skin marks, discoloration, ecchymosis and report promptly, to investigate accident as needed (PRN) and to in-service staff on abuse and neglect. The Comprehensive Care Plan for Behavioral Symptoms related to Fabrication/Accusatory Behavior dated 12/01/2025 documented Resident #116 exhibited verbal behavioral symptoms related to fabricating and accusing others. The behavioral symptoms are noted to put the resident at significant risk for physical illness or injury. Interventions included to assess for unrecognized need and preferences, to separate from others when agitated. The care plan did not document specific dates and events of accusatory behaviors. A review of the facility's Accident and Incident Report dated 11/23/2025 documented that on 11/23/2025 at approximately 2:00 AM Resident #116 reported to Licensed Practical Nurse # 5 that someone wanted to hurt their arm. Licensed Practical Nurse # 5 reported the allegation to Registered Nurse #2. Registered Nurse # 2 initiated the Accident and Incident report. The Assistant Director of Nursing Services signed for the Director of Nursing Services on 11/24/2025 and notified the New York State Department of</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Health.A written statement by Licensed Practical Nurse # 5 dated 11/25/2025 documented that during the 11/22/2025 to 11/23/2025 overnight shift, Resident #116 reported that an aide from the previous shift made a statement about breaking the resident's already injured hand. The resident expressed fear regarding this comment. Licensed Practical Nurse # 5 provided assurance of safety and reported the allegation to the Registered Nurse supervisor immediately.A statement from Resident #116, written by the Assistant Director of Nursing Services, dated 11/24/2025 documented that the incident occurred between 3:00 PM to 4:00 PM on Saturday (11/22/2025). Resident #116 stated they had an argument with a person with a red wig whom Resident #116 had seen on the unit before. Resident #116 said something derogatory to this person, and the discussion escalated into an argument. Resident #116 stated that the person grabbed their arm and said, let me break your arm again and see how you like it. Resident #116 did not identify the person by name.The undated investigative summary, written by the Assistant Director of Nursing Services, documented that on the morning of 11/24/2025 they were notified by the Unit Manager/Supervisor that on Sunday 11/23/2025 at approximately 2:00 AM, Resident #116 reported that a short [in stature] Certified Nursing Assistant with a red wig told Resident #116 that they will hurt the resident's arm even more after Resident #116 used slur words towards the Certified Nursing Assistant. Law enforcement and the New York State Department of Health were notified. The alleged perpetrator (Certified Nursing Assistant #6) was removed from the schedule. The facility concluded there was no cause to believe abuse occurred.The Nursing Home Facility Incident Report documented the abuse allegation was submitted to the New York State Department of Health on 11/24/2025 at 4:55 PM.A review of Resident #116's medical record indicated there was no documented evidence about the abuse allegation made by Resident #116.Resident #116 was discharged from the facility on 12/27/2025 and was unavailable for interview and observation.During an interview on 01/15/2026 at 11:17 AM, Licensed Practical Nurse #5, who reported the allegation on 11/23/2025, stated that they reported the allegation made by Resident #116 to Registered Nurse # 2 immediately. Licensed Practical Nurse # 5 stated that they did not recall any details of the incident at this time.During an interview on 01/15/2026 at 12:03 PM, Registered Nurse # 2, who was the nursing supervisor on 11/23/2025 during the night shift (11:00 PM-7:00 AM), stated Licensed Practical Nurse # 5 reported to them (Registered Nurse # 2) of Resident #116's allegation of abuse around 2:00 AM on 11/23/2025. Registered Nurse # 2 stated that they immediately interviewed Resident #116 who stated that a staff member from the previous shift (3:00 PM-11:00 PM) verbally threatened to hurt their (Resident #116) arm after Resident #116 and the staff member got into an argument. Registered Nurse # 2 stated that Resident #116 denied being physically hurt. Registered Nurse # 2 stated that they did not immediately report the incident to the Director of Nursing Services or the Assistant Director of Nursing Services because they were focused on ensuring the resident's wellbeing and that the alleged perpetrator was not assigned to the resident anymore. Registered Nurse # 2 stated that they notified the Assistant Director of Nursing Services on the morning of 11/24/2025 which was more than 24 hours after the allegation was brought to their attention. Registered Nurse # 2 stated they should have reported Resident #116's abuse allegation to the Director of Nursing Services or the Assistant Director of Nursing Services but it went over my head.During an interview on 01/15/2026 at 12:32 PM, Certified Nursing Assistant #6, who was Resident #116's assigned Certified Nursing Assistant on 11/22/2025 during the evening shift (3:00 PM-11:00 PM), stated that they did not get into any argument with Resident #116 during the shift. Certified Nursing Assistant #6 stated Resident #116 did not use derogatory language towards them. Certified Nursing Assistant #6 stated they provided all care to Resident #116 that evening when the resident was in bed and did not encounter the resident in the bathroom at 4:00 PM on 11/22/2025.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Certified Nursing Assistant #6 stated that they did not verbally threaten to make resident's injured hand hurt more and they did not physically hurt the resident. During an interview on 01/15/2026 at 01:54 PM, the Assistant Director of Nursing Services stated Registered Nurse # 2 should have immediately notified them or the Director of Nursing Services to seek guidance on how to proceed with the investigation. The Assistant Director of Nursing Services stated they were made aware of the incident on Monday (11/24/2025) morning. The Assistant Director of Nursing Services stated they did not report the incident to New York State Department of Health within two hours because they only needed to report incident that resulted in serious harm within two hours and had four (4) to 24 hours to report any abuse and neglect incident without serious injury. The Assistant Director of Nursing Services stated they were not aware that all alleged abuse must be reported within two hours after the allegation was made. During an interview on 01/15/2026 at 03:01 PM, the Director of Nursing Services stated they were on vacation and were not involved in the reporting and investigating of the incident for Resident #116. The Director of Nursing Services stated that Registered Nurse # 2 should have contacted either the Administrator, the Director of Nursing Services, or the Assistant Director of Nursing Services immediately when the incident was first reported. The Director of Nursing Services stated any abuse or neglect allegation with visible injury must be reported to the New York State Department of Health and law enforcement within an hour and those that did not result in injuries must be reported to the New York State Department of Health within four (4) to 24 hours. The Director of Nursing Services stated they were not aware that all alleged abuse must be reported within two hours after the allegation was made regardless of absence of physical injuries. The Director of Nursing Services stated that they were involved in developing and reviewing the facility's Abuse policy and the policy did not include reporting timeframe requirements for all reportable incidents. During an interview on 01/15/2026 at 03:32 PM, the Administrator stated Resident #116's allegation of abuse should have been reported immediately to the Director of Nursing Services or the Assistant Director of Nursing Services on 11/23/2025 and reported to the New York State Department of Health within two hours after the abuse allegation was made. The Administrator stated that they were involved in developing and reviewing the facility's Abuse policy and the policy did not include reporting timeframe requirements for all reportable incidents. The Administrator stated that the policy should have included the timeframe requirements for all reportable incidents. During an interview on 01/20/2025 at 03:40 PM, the Medical Director stated they were involved in developing and reviewing the facility's Abuse policy. The Medical Director stated that current facility policy on Abuse did not include reporting timeframe requirements for all reportable incidents. The Medical Director stated that they expected all abuse allegations to be reported to the New York State Department of Health immediately but did not know the specific timeframe that was required for abuse allegations or for all other reportable incidents. 10 NYCRR 415.4(b)(2)</p> | | |