STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335174	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobble Hill Health Center Inc	380 Henry Street Brooklyn, NY 11201

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 - Immediate jeopardy to resident health or safety 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 review, and interviews conducted during survey, the facility failed to ensure that residents are free from physical abuse. This was evident for one of six residents (Resident #1) sampled for abuse. Specifically, the facility surveillance video dated 06/14/2026 from 09:38:24 AM through 09:39:55 AM revealed Certified Nursing Assistant #1 running out of the dining room chasing Resident #1 who walked out of the dining room into the hallway holding a banana. In the hallway, Certified Nursing Assistant #1 grabbed Resident #1 at the back of their neck and used their right hand to hit Resident #1 on the top of their head. During the incident, Resident #1 fell on the floor and hit their head on another resident's wheelchair. Resident #1 did not sustain any visible injuries. This resulted in Immediate Jeopardy to resident health and safety at Past Non-Compliance. The findings are:The facility's policy titled Resident Abuse, Neglect, Mistreatment, Involuntary Seclusion, Misappropriation of Property and Injury of Unknown Origin dated 06/09/2026 documented that each resident has the right to be free from abuse, neglect, mistreatment, involuntary seclusion, and misappropriation of property. Direct care staff are to intervene immediately to stop the activity and protect the residents.Resident #1 was admitted to the facility with diagnoses which include Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills), cerebral infraction (a blocked or narrowed blood vessel cuts off blood flow to the brain) and congestive heart failure (heart muscle becomes too weak or stiff to pump blood efficiently). The Minimum Data Set (a resident assessment tool) dated 04/01/2026 documented Resident #1 had a Brief Interview for Mental Status (used to determine attention, orientation, and ability to recall information) score of 6 out of 15, denoting severely impaired cognition. A 04/02/2026 Comprehensive Care Plan titled Abuse/Neglect documented interventions to assess the resident for signs and symptoms of abuse and/or neglect, to ensure the resident feels safe as it relates to abuse or neglect. The abuse care plan was updated post incident of abuse on 06/14/2026 with interventions to monitor delayed injuries.A behavior care plan dated 04/07/2026 documented interventions for staff to monitor resident closely, attempt to anticipate behavior and redirect as needed. The facility surveillance video dated 06/14/2026 from 09:38:24 AM through 09:39:55 AM revealed Certified Nursing Assistant #1 running out of the dining room chasing Resident #1 who walked out of the dining room into the hallway holding a banana. In the hallway, Certified Nursing Assistant #1 grabbed Resident #1 at the back of their neck and using their right hand, hit Resident #1 on the top of their head. During the incident, Certified Nursing Assistant #1 grabbed Resident #1's hands and Resident #1 staggered backwards and landed on the floor in a seated position, striking their head on a wheelchair where another resident was seated. Certified Nursing Assistant #1 then attempted to pick Resident #1 up from the floor, but Resident #1 resisted. Certified Nursing Assistant #1 then let go of Resident #1's hands, picked up the banana from the floor, and then hit Resident #1 on their upper back while the other resident was watching the incident. Certified Nursing Assistant #1 then walked away (into a room) leaving Resident #1 sitting on the floor. The surveillance video ended at 09:39:55 AM.No staff members were seen in the hallway during the incident between Resident #1 and Certified Nursing assistant #1. Two residents were observed sitting in wheelchairs in the hallway (only one resident (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	appeared to be watching incident) with overbed tables in front of them. The Summary of Investigation dated 06/14/2026 documented at approximately 9:40 AM, Certified Nursing Assistant #1 observed Resident #1 exit the dayroom with a banana in their hand. Certified Nursing Assistant #1 went to Resident #1 to retrieve the banana. Certified Nursing Assistant #1 then grabbed Resident #1 by their posterior neck and while they were struggling with Resident #1 for the banana, Resident #1 fell on the floor landing on their buttocks. Certified Nursing Assistant #1 proceeded to grab the banana from Resident #1 while Resident #1 was still on the floor. Resident #1 had no visible injuries, no changes in behavior or mental status and did not recall the incident. Certified Nursing Assistant #1 was immediately escorted off the unit while Assistant Director of Nursing remained with Resident #1 until local law enforcement arrived. Certified Nursing Assistant #1 was interviewed by local law enforcement officers; then escorted out of the building. The investigation concluded that Certified Nursing Assistant #1 physically abused Resident #1. On 06/15/2026 an x-ray was done of Resident #1's cervical spine, bilateral hips, sacrum and coccyx. The x-ray results revealed no fracture.A nursing progress note dated 06/14/2026 at 4:25 PM by Licensed Practical Nurse #1, documented on 06/14/2026 at 9:30 AM, Resident #1 was observed sitting on the floor in the hallway.A nursing progress note dated 06/14/2026 at 10:48 PM by Assistant Director of Nursing #1, documented at around 9:50 AM, writer was called to the unit by Licensed Practical Nurse #1 who informed them that Resident #1 was struck by Certified Nursing Assistant #1. On arrival, Resident #1 was observed sitting on the floor upright. Body assessment revealed no visible injury at this time. Physician's progress note dated 06/18/2026 at 3:50 PM documented resident was seen secondary to having been physically abused. Resident #1 has dementia and does not recall the incident. During an interview on 06/24/2026 at 12:03 PM, Certified Nursing Assistant #1 stated they were monitoring the dining room the morning of 06/14/2026. They stated that at approximately 9:39 AM, they followed Resident #1 out of the dining room. Certified Nursing Assistant #1 stated they did not hit Resident #1, but while they were struggling to take the banana from Resident #1, the resident fell onto the floor. During an interview on 06/24/2026 at 12:47 PM, Certified Nursing Assistant #2 stated that on 06/14/2026 (unsure of time), they observed Resident #1 sitting on the floor in the hallway screaming and Certified Nursing Assistant #1, who was standing over Resident #1, punched Resident #1 on their upper back with a closed fist. They called out to Certified Nursing Assistant #1 and asked them what they were doing, but they did not respond. Certified Nursing Assistant #2 stated Licensed Practical Nurse #1, who was inside the nursing station, came to see what was happening (unsure of time). During an interview on 06/24/2026 at 1:50 PM, Licensed Practical Nurse #1 stated that on 06/14/2026, they were at the nursing station (unsure of time) when they heard Resident #1 screaming in Spanish from the hallway at around 9:40 AM. Licensed Practical Nurse #1 stated they left the nursing station and observed Resident #1 sitting on the floor in the hallway and Certified Nursing Assistant #1 appeared to be hitting the resident on their back. Licensed Practical Nurse #1 stated they instructed Certified Nursing Assistant #1 to stay away from Resident #1 and then, using their cell phone, immediately called the Assistant Director of Nursing and informed them of the incident. During an interview on 06/24/2026 at 3:17 PM, Registered Nurse #1 stated they were performing a medication pass in the hallway when they heard Resident #1 yelling, but they could not understand what Resident #1 was saying. Registered Nurse #1 stated they looked to see what was happening and they observed Licensed Practical Nurse #1, who was the charge nurse, screaming at Certified Nursing Assistant #1 telling them to stop what they were doing to Resident #1. Registered Nurse #1 stated they observed Resident #1 sitting on the floor and Certified Nursing Assistant #1 using their closed hand to punch Resident #1 in their back. During an interview on 06/24/2026 at 11:16 AM, Assistant Director of Nursing #1 stated that on the day of the incident, they were called by Licensed Practical Nurse #1 at approximately 9:50 AM, informing them that they saw Certified Nursing Assistant #1 hitting Resident #1. Assistant Director of Nursing #1 stated they immediately went to the unit and observed Resident #1 sitting on the floor in the hallway and Certified Nursing Assistant #1 standing at the entrance of (continued on next page)

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Assistant Director of Nursing #1 stated after they completed the resident's assessment, they escorted Certified Nursing Assistant #1 off the unit to the nursing office where they stayed until local law enforcement arrived. Assistant Director of Nursing #1 stated they notified the Director of Nursing and called 911. Assistant Director of Nursing #1 stated they continued to monitor Resident #1 for changes, and there were no changes from their baseline. During an interview on 06/25/2026 at 12:41 PM, Medical Doctor #1 stated they were made aware of the incident on 06/15/2026 by the Assistant Director of Nursing who reported that Certified Nursing Assistant #1 struck Resident #1. Medical Doctor #1 stated they performed a full physical assessment and emotional assessment and there were no visible injuries or changes in mental status in Resident #1. Medical Doctor #1 stated Resident #1 was unable to recall the incident.During an interview on 06/25/2026 at 11:49 AM, the Administrator stated the Director of Nursing informed them on 06/14/2026 at approximately 10:00 AM, that there was an incident of abuse at the facility on the 5th floor. The Administrator stated they informed their Chief Executive Officer and came to the facility at approximately 10:30 AM. The Administrator stated they reviewed the surveillance video and when the police officers arrived at the facility it was reviewed again. The Administrator stated they spoke to the police officers after they reviewed the surveillance video. The Administrator stated that the police officers interviewed Certified Nursing Assistant #1, then escorted them out of the facility to the police car. The Administrator stated that Resident #1's plan of care was discussed and interventions implemented. During an interview on 06/25/2026 at 12:57 PM, the Director of Nursing stated that when they were notified of the incident, they immediately instructed the Assistant Director of Nursing to call 911 and then notified the Administrator. The Director of Nursing stated that local law enforcement arrived at the facility at approximately 11:00 AM and reviewed the surveillance video recording. The Director of Nursing stated the police officers called their supervisor who also came to the facility, and they were escorted to Resident #1's unit. The Director of Nursing stated the police officers spoke with Resident #1 and staff members who witnessed the incident. The Director of Nursing stated that the police officers handcuffed Certified Nursing Assistant #1 at the police car.Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to surveyors' s onsite visit on 06/24/2026. A Plan of Correction is not required for this citation.10 New York Codes, Rules and Regulations 415.4(b)(1)(i)The facility took immediate corrective actions and was found to be in substantial compliance on 06/23/2026.On 06/14/2026, facility immediately removed Certified Nursing Assistant #1 off the unit and subsequently terminated them on 06/19/2026. On 06/14/2026 local law enforcement was contacted and escorted Certified Nursing Assistant #1 out of facility.On 06/14/2026, the Assistant Director of Nursing assessed Resident #1 with no visible injuries. Radiology Report of bilateral hips with pelvis, coccyx, spine and skull dated 06/14/2026 was negative for fracture. On 06/15/2026 the Resident was assessed by a psychiatrist who determined there was no changes in mental or psychosocial status; the resident did not recall the incident. On 06/14/2026, the abuse policy was reviewed with no revisions. On 06/14/2026, an Interdisciplinary Stand-up Meeting was held post-incident.On 06/14/2026 in-service on resident abuse was initiated for all staff with 83% of available staff receiving education to date and education remains is ongoing. On 06/15/2026, registered nurses conducted a skin assessment on all (continued on next page)

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