

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Silver Lake Specialized Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 275 Castleton Avenue Staten Island, NY 10301	

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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review and interviews conducted during an abbreviated survey (2691440). the facility failed to ensure that a resident was free from abuse. This was evident for one (1) of seven (7) residents (Resident #1) sampled for abuse. Specifically, on 12/11/2025 at 5:23:43 PM the facility's surveillance camera footage shows Certified Nursing Assistant #1 approach Resident #1 in the dayroom and pulled the dayroom table away from Resident #1's wheelchair. At 5:23:56 PM, Certified Nursing Assistant #1 was observed hitting Resident #1 on the back of their head with an open hand and Resident #1's head falls forward. At 5:24 PM, Certified Nursing Assistant #1 pushed Resident #1's wheelchair to the dayroom exit door and stop. At 5:24.12 PM, at the dayroom exit door Certified Nursing Assistant #1 was observed taking items out of Resident #1's wheelchair when Resident #1 throw a cup of liquid on Certified Nursing Assistant #1. Certified Nursing Assistant #1 then hit Resident #1 on their upper arm two times with a white paper plate. The findings are:The facility's Policy and Procedure on the Abuse Prevention Program dated 01/2023, documented residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Any case in which abuse, neglect, mistreatment, exploitation or misappropriation of resident's property has been identified via the investigation or abuse cannot be ruled out will be reported promptly to the New York State Department of Health for further investigation.Resident #1 was admitted to the facility with diagnoses of dementia, restlessness and agitation, major depressing disorder, and obsessive-compulsive disorder. The Minimum Data Set (a resident assessment tool) dated 09/25/2025, documented that Resident #1's cognition was moderately impaired.A review of the Comprehensive care plan for abuse prevention dated 07/16/2025, documented interventions to intervene as necessary to ensure safety of residents, remove resident from area of the aggressor. Nursing Home Facility Incident Report dated 12/11/2025 documented while reviewing the camera footage of another incident in the unit dayroom, Certified Nursing Assistant #1 was seen tapping Resident #1 on the head on 12/11/2025 at 5:23 PM. Certified Nursing Assistant #1 was taking Resident #1 out of the dayroom after dinner when Resident #1 began calling Certified Nursing Assistant #1 rude, offensive and vulgar names repeatedly. Certified Nursing Assistant #1 was immediately removed from the unit and replaced with another staff member. Resident #1 was evaluated for injury and no injury noted and did not feel fearful. Facility investigation conclusion documented there was cause to believe abuse had occurred. Nursing progress note dated 12/11/2025 at 8:35 PM, written by the Director of Nursing documented when reviewing the camera footage on 12/11/2025 at 5.45 PM, they observed Certified Nursing Assistant #1 tapping Resident #1 in the back of their head. Resident #1 was assessed immediately with no visible injury. Resident #1 denied having any pain or discomfort. Emotional support and referred to psychiatry and psychology for assessments.A documented titled 'CNA Clinical Accountability Record and Assignment' dated 10/1/25, 11/1/25, and 12/1/25 documented instructions to approach/speak to resident calmly.During an interview on 12/16/2025 at 10:04 AM, Resident #1 stated Certified Nursing Assistant #1 did not tapped their head, Certified Nursing Assistant #1 slapped them on their head, and it hurt. Resident #1 stated they did not tell anyone about their headache. Resident #1 stated Certified Nursing Assistant #1 pulled their wheelchair out of the dayroom and took them to their room. Resident #1 stated Certified Nursing Assistant #1 is the only staff member who ever hit them. During an interview of five (5) residents (Resident #2, #3, #4, #5, #6) assigned to Certified Nursing Assistant #1, they all stated they have no issues with Certified Nursing Assistant #1 or any other staff. No one abused them and they have never witnessed any staff abusing residents. During an interview on 12/16/2025 at 11:21 AM, Certified Nursing Assistant #1 stated the incident happen shortly after supper at approximately 5:45 PM to 5:50 PM. Certified Nursing Assistant #1 stated there was a verbal altercation between Resident #1 and Resident #2. Certified Nursing Assistant #1 stated Resident #1 accused Resident #2 of eating with their hand and called Resident #2 derogatory words. Certified Nursing Assistant #1 stated Resident #2 started getting restless and they did not want any physical altercation between both residents, so they move Resident #1 away from Resident #2. Certified Nursing Assistant #1 stated that Resident #1 started cursing at them using derogatory words (such as black bitch and to go back to their country). Certified Nursing Assistant #1 they raised their hand and slap Resident #1 in their head. Certified Nursing Assistant #1 stated they took Resident #1 to their room after the incident. Certified Nursing Assistant #1 stated they have never done this before, and they know that what they did was wrong. Certified Nursing Assistant #1 stated they have been working at the facility for three and half years and received in-service on abuse prevention During an interview on</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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</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>Based on interview and record review conducted during an abbreviated survey (2691440), the facility did not ensure that an alleged violation involving abuse, neglect, mistreatment, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involved abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including to the State Agency and adult protective services where state law provides for judications in long term care facilities). This was evident for one (1) out of seven (7) residents (Resident #1) sampled for abuse. Specifically, on 12/11/2025 at 5:23:43 PM the surveillance camera footage shows Certified Nursing Assistant #1 approach Resident #1 in the dayroom and pulled the dayroom table away from Resident #1's wheelchair. At 5:23:56 PM, Certified Nursing Assistant #1 was observed hitting Resident #1 on the back of their head with an open hand and Resident #1's head falls forward. At 5.24.12 PM at the dayroom exit door Certified Nursing Assistant #1 was observed taking items out of Resident #1's wheelchair when Resident #1 throw a cup of liquid on Certified Nursing Assistant #1. Certified Nursing Assistant #1 went on to hit Resident #1 on their upper arm two times with a white paper plate. The facility did not report the alleged incident to local law enforcement. The findings include: The facility's policy and procedure titled Abuse Investigation dated 01/2023 document that all reports of resident abuse, neglect, mistreatment, sexual abuse, willful, exploitation, misappropriation of resident's property, adverse event, person center care, resident representative, and injury of unknown source shall be promptly and thoroughly investigated by the facility management. It also documented the facility will report any incident and/or violation where abuse, neglect, mistreatment neglect, sexual abuse, willful, exploitation, misappropriation of resident's property, adverse event, person centered care or resident representative is suspected to the New York State Department of Health according to protocol. Additionally, Federal law (150B of the Social Security Act)' requires that any individual employee having reasonable suspicion that a crime has occurred against a resident is required to report the suspicion to Law Enforcement and the State Agency. If the crime involves serious bodily injury it must be reported immediately, but no later than 2 hours after forming the suspicion or if the crime does not appear to cause serious bodily injury you must report it within 24 hours of forming the suspicion. Resident #1 was admitted to the facility with diagnoses of dementia, restlessness and agitation, major depressing disorder and obsessive-compulsive disorder. Minimum Data Set (a resident assessment tool) dated 09/25/2025, documented that Resident #1's cognition was moderately impaired. Nursing Home Facility Incident Report dated 12/11/2025 documented while reviewing the camera footage of another incident in the unit dayroom, Certified Nursing Assistant #1 was seen tapping Resident #1 on the head on 12/11/2025 at 5:23 PM. Certified Nursing Assistant #1 was taking Resident #1 out of the dayroom after dinner when Resident #1 began calling Certified Nursing Assistant #1 rude, offensive and vulgar names repeatedly. Certified Nursing Assistant #1 was immediately removed from the unit and replaced with another staff member. Resident #1 was evaluated for injury and no injury noted and did not feel fearful. Facility investigation conclusion documented there is cause to believe abuse has occurred. During an interview on 12/16/2025 at 2:59 PM, Director of Nursing stated on 12/11/2025 at 5:45 PM while reviewing the surveillance camera footage of another incident they observed Certified Nursing Assistant #1 was seen tapping Resident #1 in the back of their head. Director of Nursing stated that they immediately remove Certified Nursing Assistant #1 from the unit. Evaluated Resident #1 for any injury. Director of Nursing stated they were no visible injury noted. Director of Nursing stated the Administrator is the one who is responsible for reported the incident to the different agency. During an interview on 12/17/2025 at 2:00 PM, the Administrator stated they were informed by Director of Nursing of the alleged incident and watch the video in the dayroom. The Administrator stated they reported the incident to Department of Health, but they never reported the incident to local law enforcement. Administrator stated they observed Certified Nursing Assistant #1 tapping Resident #1 on their head, but they did not think they should have reported the incident to local law enforcement. 10 NYCRR 482.12(c)</p>		