STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335232	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Upper East Side Rehabilitation and Nursing Center	211 East 79 St New York City, NY 10075

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 - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on interview and record review conducted, the facility did not have evidence that all alleged violations were thoroughly investigated. This was evident for one (1) out of seven (7) residents (Resident #1) reviewed for abuse. Specifically, Resident #1 reported that on 08/20/2025 a middle-aged worker (later identified as Certified Nursing Assistant #1) came into their room to change their brief between the hours of 11:30 PM and midnight and punched them in the face. There was no documented evidence that the facility took measures to facilitate Resident #1's ability to identify the person alleged to have assaulted them.A review of the facility's investigation found that it dismissed the resident's claim that they were assaulted by Certified Nursing Assistant #1 because the facility found that Certified Nursing Assistant #2 (who did not fit the description given by the resident) provided incontinent care to Resident #1 on 08/21/2025 between 3:30 AM and 4:00 AM. A review of the unit assignment sheet revealed that Certified Nursing Assistant #1 was not assigned to provide care to Resident #1 but provided safety checks on the unit between 11:30 PM to midnight on 08/20/2025 and was observed in Resident #1's room at that time.The findings include:The facility's policy and procedure title Reporting and Investigation of Resident Abuse, Neglect, Misappropriation/Exploitation and Mistreatment last revised on 10/2022, documented all personnel have the responsibility to report any incident or suspected incident of resident abuse, including injuries of an unknown source. The facility shall conduct a thorough investigation of all alleged violations involving exploitation, mistreatment, neglect or abuse, and misappropriation of resident property and comply with stated reporting regulations. Alleged violations and results of investigations shall be reported immediately to administrator/Director of Nursing Service.Resident #1 was admitted to the facility with diagnoses of Adjustment Disorder, Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure.The Minimum Data Set (a resident assessment tool) dated 06/24/2025 documented Resident #1 had intact cognition.A review of the facility's Investigation dated 08/21/2025 documented Resident #1 reported to Activities Department staff that last night at approximately 11:30 PM to midnight, a worker came into their room and engaged in a conversation, joking around then suddenly punched them in the face. A complete body assessment was done and there were no visible injuries noted. Resident #1 was re-interviewed and alleged that the person is a female middle aged with lighter skin, who punched them in the face. Resident #1 stated they had interactions with this staff member before, and the staff was not friendly. Resident #1 stated that the staff member came into their room to change their brief. A review of the unit staffing revealed Certified Nursing Assistant #1 was not assigned to Resident #1 and that Certified Nursing Assistant #2 was assigned to Resident #1 from 08/20/2026 to 08/21/2026 and provided care to Resident #1 at approximately 3:30 AM - 4:00 PM on 08/21/2026 and has a dark complexion and did not fit Resident #1's description. Certified Nursing Assistant #1, who was not assigned to Resident #1, provided rounding on 08/20/2026 to 08/21/2026 at 11:30 PM to midnight and stated Resident #1 was asleep during rounding. Both Certified Nursing Assistants stated they did not punch Resident #1. Resident #1's roommate who is alert and oriented x three (3) stated they never witnessed staff member punching Resident #1 in the face. Law enforcement was notified and Resident #1 refused to speak to the Police Officers. The facility investigation concluded that there was no evidence that physical (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	abuse, neglect or mistreatment had occurred. The investigation also revealed that Certified Nursing Assistant #1 was suspended because they fit Resident #1's description. There was no documented evidence that the facility took measures to facilitate Resident #1's ability to identify the person they alleged to have assaulted them. Certified Nursing Assistant #2 was not removed from direct access to residents during the investigation.A review of the Daily Resident Room Check (30 minutes) document dated 08/20/2025 for the 11:00 PM - 7:00 AM shift revealed Resident #1 was in bed asleep from 11:30 PM through 3:00 AM as evidence by Certified Nursing Assistant #1 and Certified Nursing Assistant #3's signatures. At 3:30 AM incontinent care was provided to Resident #1 as evidenced by Certified Nursing Assistant #2's signature.A review of the unit Assignment Sheet dated 08/20/2025 for 11:00 PM - 7:00 AM (08/21/2025) shift showed Certified Nursing Assistant #2 was assigned to Resident #1.Former Director of Nursing who investigated the alleged allegation of abuse no longer works at the facility and whereabouts are unknown.During an interview on 04/15/2026 at 9:49 AM, Resident #1 stated they recalled that the incident took place on 08/20/2025 at 11:00 PM to 08/21/2025 midnight. Resident #1 stated that a staff member came into their room to clean them, and that the staff member joked around with them then suddenly punched them in the face. Resident #1 stated they do not recall where on their face they were punched but that the person who punched them was light skin. Resident #1 also stated they recalled being punched above the belt. Resident #1 stated they never felt pain, and they did not scream or call out for help. Resident #1 stated they have not seen the staff member since incident. Resident #1 stated that two (2) Police Officers came into their room, but they did not speak to the Officers as they did not call them.During a follow up interview with Resident #1 on 05/01/2026 at 3:06 PM, Resident #1 stated that the light skin person who punched them is the same person who provided care to them. Resident #1 went on to say that the staff punched them while they were providing care. Resident #1 stated they are unsure how many times they were punched and do not recall if the light was on.During an interview on 04/15/2026 at 11:50 AM, Certified Nursing Assistant #1 stated they worked on Resident #1's unit from 08/20/2025 to 08/21/2025 on the 11:00 PM to 7:00 AM shift. Certified Nursing Assistant #1 stated they took turns performing rounding at different times during the shift. Certified Nursing Assistant #1 stated they recalled Certified Nursing Assistant #2 in Resident #1's room providing care to them when they were conducting one of their rounding (unsure of time) on 08/21/2025. Certified Nursing Assistant #1 stated they did not witness Certified Nursing Assistant #2 punched or argued with Resident #1. Certified Nursing Assistant #1 stated they were not assigned to Resident #1 but provided rounding in Resident #1's room. Certified Nursing Assistant #1 stated they were suspended for two days.During an interview on 04/15/2026 at 12:21 PM, Certified Nursing Assistant #2 stated they worked on 08/20/2025 on the 11:00 PM to 7:00 AM shift and was assigned to Resident #1. Certified Nursing Assistant #2 stated they work as a floater, and this was not the first time being assigned to Resident #1. Certified Nursing Assistant #2 stated Resident #1 did not report that they were punched by anyone and never complained of feeling pain or discomfort. Certified Nursing Assistant #2 stated there was no verbal or physical altercation between them and Resident #1 and that they did not punch Resident #1 in the face. Certified Nursing Assistant #2 stated they were not suspended.During an interview on 04/15/2026 at 12:39 PM, Director of Social Service #1 stated after they received notice of the alleged allegation of abuse, they and Registered Nurse Supervisor #2 immediately interviewed them. Director of Social Service #1 stated that Resident #1 reported that a light skin middle-aged staff came into their room to change them and that the staff punched them in the face on 08/20/2025 between 11:00 PM to midnight, in the early hours on 08/21/2025. Director of Social Service #1 stated Resident #1 reported that the staff person was not friendly. Director of Social Service #1 stated Resident #1 said it was not the first time this staff person had worked with them. Director of Social Service #1 stated Resident #1 was assessed by Registered Nurse Supervisor #2 with no visible injuries. Director of Social Service #1 stated that Certified Nursing Assistant #1 was the only light skin person who worked on the unit on that night, however, Certified Nursing Assistant #1 was not assigned to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #1 and did not provide care to them. Director of Social Service #1 stated that Certified Nursing Assistant #1 denied punching Resident #1. Director of Social Service #1 stated they interviewed Resident #1 twice and Resident #1 stated it was a light skin person who punched them in the face. Director of Social Service #1 stated based on Resident #1's description, that Certified Nursing Assistant #2 did not fit the description. During an interview on 04/16/2026 at 12:53 PM, the Director of Nursing stated they were on vacation when the alleged allegation was reported and that they do not recall the incident. The Director of Nursing stated if they had conducted the investigation they would have investigated and suspended both Certified Nursing Assistant #1, who conducted rounding, and Certified Nursing Assistant #2, who was assigned and provided care to Resident #1, while the investigation was pending. The Director of Nursing stated Certified Nursing Assistant #1 was suspended because of Resident #1's description.During an interview on 04/17/2026 at 2:21 PM Registered Nurse Supervisor #1 stated they worked on 08/20/2025 on the 11:00 PM - 7:00 AM (08/21/2025) shift but was not notified of the alleged allegation of abuse. Registered Nurse Supervisor #1 stated they were informed by the former Director of Nursing that Resident #1 reported an allegation of abuse on the 11:00 PM - 7:00 AM shift. Registered Nurse Supervisor #1 stated they went to Resident #1's room and performed a body assessment and they observed no redness, discoloration, bruising, or visible injuries and Resident #1 had no complaint of pain. 10 New York Codes, Rules, and Regulations 415.4(b)(3)