STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335445	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Triboro Center for Rehabilitation and Nursing	1160 Teller Ave Bronx, NY 10456

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 6Number of residents cited: 1 Based on record review and interviews, the facility failed to ensure each resident was free from chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. This was evident for one (1) of six (6) residents (Resident #425) reviewed for Unnecessary Meds, Chemical Restraints/Psychotropic Meds, and Med Regimen Review, out of 38 sampled residents investigated. Specifically, Resident #425 was administered psychotropic drugs without an appropriate diagnosis, there was no documentation of behaviors to support the ongoing use of psychotropic medications, and there was no evidence of monitoring for effectiveness or side effects.The findings are:The facility policy and procedure titled Psychotropic Medication dated 10/2024, last revised 04/28/2025 state psychotropic medications may be prescribed for and administered to residents in accordance with current standards of practice and State and Federal Regulations to promote and/or maintain the resident's highest practicable mental, physical, and psychosocial well-being.Resident #425 was admitted with diagnoses that included Non-Alzheimer's Dementia, Depression, and Bipolar Disorder.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #425 has severe impairment in cognition, had no potential indicators of Psychosis, and no presence of behavioral symptoms documented. The Minimum Data Set assessment also documented that Resident #425 was taking antipsychotic medication with an indication noted, a gradual dose reduction had not been attempted, and the physician had not documented Gradual Dose Reduction as clinically contraindicated.The Physician's order dated 12/23/2025 documented Seroquel 125 milligrams orally at bedtime for dementia with behavioral disturbance. A care plan titled Behavior dated 10/22/2025 and updated 12/15/2025 documented Resident exhibits behavior symptoms such as hoarding food in drawers, urinating in the dustbin, on the floor in the room and refusing care /showers. Interventions included attempt to establish a daily routine, check for toileting need, provide toileting/incontinence care as indicated, determine the cause of the behavior and maintain residents' safety, and re-approach resident for care/toileting/medication administration/treatments and other needs when resident is more agreeable. The Monitoring/Evaluation notes dated 12/15/2025 documented the appropriate department has been notified to please add extra snacks for Resident #425 throughout the day. There were no other behavior monitoring/evaluation notes documented in Resident #425 clinical record to indicate escalation of behavior and/or effectiveness of interventions in place.A care plan titled Dementia dated 09/19/2025 documented resident has impaired cognition related to Dementia. Interventions included engage the resident to participate in simple, structured activities, keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, and monitor/document /report to nurse and medical provider any changes in cognitive function. The Monitoring/Evaluation notes did not include documented evidence of the effectiveness of interventions being provided. A care plan titled Psychoactive Medications dated 09/19/2025 documented resident uses psychoactive medications related to diagnosis of Depression. Interventions included give medications ordered by physician, monitor/document side effects and (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effectiveness, and monitor/record occurrence of target behavior symptoms and document per facility protocol. The Monitoring/Evaluation notes did not include documented evidence Resident #425 was monitored for behavior and effectiveness of psychotropic medications. The Physician's order dated 12/23/2025 documented Seroquel 125 milligrams orally at bedtime for dementia with behavioral disturbance. The Psychiatric Comprehensive Consult dated 09/26/2025 documented Resident #425 was seen for initial assessment for psychiatric evaluation and medication management. Resident #425 was noted alert, awake, and doing well, reported good sleep and appetite. The consult also documented Resident #425 has diagnoses of Major Depressive Disorder, and Dementia without behavioral disturbance. The consult further documented follow up should occur in 3 months and as needed, and staff was to monitor mood and behavior and document accordingly.The Psychiatric Comprehensive Consult dated 11/07/2025 documented Resident #425 was seen for follow up assessment for psychiatric evaluation and medication management. Resident alert, awake, doing well and noted calm. The recommendations were to continue Seroquel 125 milligrams by mouth at bedtime and non-pharmacological interventions. The consult further documented follow up should occur in 3 months and as needed, and staff was to monitor mood and behavior and document accordingly.The Psychiatric Comprehensive Consult dated 12/29/2025 documented Resident #425 was seen for follow up assessment for psychiatric evaluation and medication management and resident was alert, awake, not doing well on current medication, noted to be irritable with disorganized behaviors. The consult also documented staff reported poor sleep and medications would be adjusted. Start Trazodone 25 milligrams by mouth every 12 hours, increase Seroquel to 150 milligrams by mouth at bedtime, and non-pharmacological interventions. The consult further documented follow up should occur in 3 months and as needed, and staff was to monitor mood and behavior and document accordingly. There was no documented evidence of behaviors to support ongoing use of psychotropic medication for Resident #425, or evidence that the effectiveness or side effects of resident's psychotropic medications was monitored or documented.A complaint was submitted by Resident #425's family member in October 2025 which stated they had concerns that Resident #425 had never been diagnosed with Bipolar disorder and was receiving psychotropic medications while having a diagnosis of Dementia. The family also stated Resident #425 has a Dementia diagnosis and can have aggressive behavior as a result and they were seen by a psychiatrist in the community and was not prescribed medication for their behavior. The family further stated they visit regularly and have not observed Resident #425 with aggressive or violent behaviors and think the medication will only worsen Resident #425's condition. The family also stated they had not been informed that Resident #425 was being started on this medication.During an interview on 03/08/2026 at 01:15 pm, the Complainant stated that they had been talking to Resident #425's primary physician at the facility to stop certain medications prescribed due to the increased risk for residents with a diagnosis of dementia. The Complainant also stated the medications were not discontinued until they called 911 in January 2026 and had Resident #425 transferred back to the hospital and then placed in another nursing home. During an interview on 03/12/2026 at 10:54 AM, Certified Nursing Assistant #1 stated that they were not directly assigned to Resident #425, but they never observed Resident #425 with any aggressive behavior on the unit. Certified Nursing Assistant #1 also stated that due to dementia sometimes Resident #425 had could not find their room and was always re-directed. Certified Nursing Assistant #1 further stated Resident #425 used to attend recreation activities on the unit and would eat meals in the dining room with other residents.On 03/12/2026 at 11:05 AM, Certified Nursing Assistant #2 was interviewed and stated they were assigned to Resident #425 for about a month and assisted them with Activities of Daily Living. Certified Nursing Assistant #2 also stated Resident #425 would sometimes refuse shower sand get agitated when being encouraged to take shower, so sometimes additional staff would be needed to assist, or the resident's family would come to assist with the shower.During an interview on 03/12/2026 at 12:28 PM, Licensed Practical Nurse #1 stated Resident #425 sometimes refused to shower on regular basis, but with encouragement would agree to take it (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when the staff returned later. Licensed Practical Nurse #1 also stated that they could not recollect seeing Resident #425 with any other abnormal behavior, and no staff reported any aggressive behavior to them during Resident's #425 stay in the facility.On 03/12/2026 at 12:33 PM, Registered Nurse #1 was interviewed and stated Resident #425 was admitted from the hospital in September 2025 with Seroquel 150milligrams at bedtime, which was continued by the psychiatrist on 09/26/2025, and on 11/07/2025, it was reduced the Seroquel to 125 milligrams for major depressive disorder/adjustment disorder. Registered Nurse #1 also stated the indication of Seroquel was not documented at the hospital. Registered Nurse #1 further stated Resident #425 was observed and monitored by the staff, was refusing care most of the time and would be aggressive when being encouraged by staff and sometimes when the family was present. Registered Nurse #1 stated that they were not on duty when Resident's medication was reduced and could not explain why the reduction was not documented and updated in the resident's care plan when the medication was decreased.On 03/13/2026 at 9:47 AM, the Psychiatrist was interviewed and stated Resident #425 was discharged from the hospital on Seroquel 150 milligrams at bedtime, was seen for initial assessment, based on hospital discharge record reviewed, Resident #425 was apparently sent from home to the hospital with 150 milligrams of Seroquel, and their child had expressed that Resident #425 could not be handled at home due to behavior problem. The Psychiatrist also stated that the hospital records documented that Resident #425 was well managed with Seroquel 150 milligrams, and a recommendation was given to continue on that same dose in the nursing home to avoid deterioration. The Psychiatrist further stated that during a follow up visit in November, Resident #425 was noted to be doing well, so Seroquel was decreased to 125 milligrams at bedtime. During the follow-up visit in December, staff reported that Resident #425 was having increased behavior and poor sleep, recommendation given to start Trazodone 25 milligrams every 12 hours, and Seroquel increased to 150 milligrams at bedtime and Resident was to be re-evaluated in January but was transferred back to the hospital. The Psychiatrist stated that they are aware of the black box warning, and they usually do Gradual Dose Reduction and give alternative medication, but Resident #425's behavior was very aggressive, and the only medication that helped was Seroquel, so they felt compelled to continue the same medication. The Psychiatrist also stated other medication was tried at the hospital and Resident #425 was only able to be managed on Seroquel, and they did not think it would be good to take them off the medication as they had been stabilized on that medication. On 03/13/2026 at 12:06 PM, the Medical Director was interviewed and stated that Resident #425 was discharged with a high dose of Seroquel 150 milligrams and titrated to 125 milligrams at the nursing home. The Medical Director also stated that the indication was mistakenly documented as only for dementia on the Physician's order. The Medical Director further stated that based on the psychiatry evaluation, Resident #425 also had a diagnosis of Major Depressive Disorder, and other psychotic behavior that should have been indicated on the order. The Medical Director stated that it would not be wise to reduce Resident's Seroquel from 150 milligrams that they were receiving on admission they need to monitor resident further before considering gradual dose reduction. The Medical Director also stated that staff were not properly documenting resident's behaviors, but they cannot just stop the medication that a resident has been taking prior admission.On 03/13/2026 at 12:58 PM, the Director of Nursing was interviewed and stated that the Seroquel was being given for bipolar disorder, but the diagnosis was wrongly selected when the orders were entered. The Director of Nursing was not able to explain why there was no documented evidence of monitoring Resident 425's behavior or the effectiveness of the psychotropic medication being given.On 03/13/2026, between 9:00 AM and 12:30 PM, two (2) attempts were made to speak with Resident #425's primary physician which were both unsuccessful. 10 New York Code, Rules and Regulations 415.3(d)(1)(vii)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 2Number of residents cited: 1 Based on interviews and record review, the facility failed to ensure all alleged violations involving abuse were reported immediately to the New York State Department of Health but not later than 2 hours after the alleged occurrence. This was evident for one (1) of two (2) residents (Resident #426) reviewed for Abuse out of 38 total sampled residents. Specifically, Resident #426 sustained an unwitnessed injury to the upper right eyelid which they could not explain, which was not reported to Department of Health. The findings are: The facility policy titled Abuse Prevention dated 07/18/2025 stated the facility must report alleged violations related to mistreatment, exploitation, neglect, or abuse including injuries of unknown source and misappropriation of resident property and report the results of all investigations to all the proper authorities within prescribed timeframes. The policy also stated alleged violations involving abuse, neglect, exploitation mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Resident #426 had diagnoses that included Alzheimer's disease, Cognitive Communication Deficit, and Depression. The Minimum Data Set assessment dated [DATE] documented Resident # 426 had severely impaired cognition, required partial assistance of one (1) person to assist with Activities of Daily Living. The Investigation Form dated 11/26/2025 documented that at 8:15 AM Certified Nurse Assistant #3 observed Resident #426 with redness on right upper eyelid and when interviewed Resident #426 stated they fell. The form also documented that Resident #426 later stated they did not know what happened. The Accident/Incident Statement Form completed by Licensed Practical Nurse #3 documented that they were called by the Certified Nursing Assistant to evaluated Resident #426 who was observed with a bump over their right eye. The statement documented that Resident #426 stated they fell, however they were not able to state how and when they fell. On 03/13/2026 at 12:38 PM, the Director of Nursing was interviewed and stated investigation of the redness on the resident's right upper eyelid was done and since Resident #426 stated at first they had fallen, the facility concluded the injury came from the fall. The Director of Nursing also stated Resident #426 is confused and cannot fully state what happened. The Director of Nursing further stated the injury to Resident #246's right eye was not reported to Department of Health since the facility had already completed their investigation. 10 New York Code, Rules and Regulations 415.4(b)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 6Number of residents cited: 1 Based on record review and interviews, the facility failed to ensure that a resident's comprehensive care plan was reviewed and revised to accurately reflect the needs of the resident and in response to current interventions. This was evident for one (1) of six (6) residents (Resident #425) reviewed for Unnecessary Meds, Chemical Restraints/Psychotropic Meds, and Med Regimen Review, out of 38 sampled residents. Specifically, there was no documented evidence that Resident #425's comprehensive care plan for psychoactive medications was reviewed and revised after medications were adjusted. The findings are:The facility policy and procedure titled Care Plans-Comprehensive dated 10/2015, last revised 08/02/2024 stated assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.Resident #425 was admitted to the facility with diagnoses that included Non-Alzheimer's Dementia, Depression, and Bipolar Disorder.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #425 has severe impairment in cognition, had no potential indicators of Psychosis, and no presence of behavioral symptoms documented. The Minimum Data Set assessment also documented that Resident #425 was taking antipsychotic medication with an indication noted, a gradual dose reduction had not been attempted, and the physician had not documented Gradual Dose Reduction as clinically contraindicated.A care plan titled Dementia dated 09/19/2025 documented resident has impaired cognition related to Dementia. Interventions included engage the resident to participate in simple, structured activities, keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, and monitor/document /report to nurse and medical provider any changes in cognitive function. The Monitoring/Evaluation notes did not include documented evidence of the effectiveness of interventions being provided. A care plan titled Psychoactive Medications dated 09/19/2025 documented resident uses psychoactive medications related to diagnosis of Depression. Interventions included give medications ordered by physician, monitor/document side effects and effectiveness, and monitor/record occurrence of target behavior symptoms and document per facility protocol. The Monitoring/Evaluation notes did not include documented evidence Resident #425 was monitored for behavior and effectiveness of psychotropic medications. Physician's order dated: 12/23/2025 documented: - Seroquel 125 mg PO at bedtime for The Physician's order dated: 12/23/2025 documented Seroquel 125 milligrams orally at bedtime for dementia with behavioral disturbance. The Psychiatric Comprehensive Consult dated 09/26/2025 documented Resident #425 was seen for initial assessment for psychiatric evaluation and medication management. Resident #425 was noted alert, awake, and doing well, reported good sleep and appetite. The consult also documented Resident #425 has diagnoses of Major Depressive Disorder, and Dementia without behavioral disturbance. The consult further documented follow up should occur in 3 months and as needed, and staff was to monitor mood and behavior and document accordingly.The Psychiatric Comprehensive Consult dated 11/07/2025 documented Resident #425 was seen for follow up assessment for psychiatric evaluation and medication management. Resident alert, awake, doing well and noted calm. The recommendations were to continue Seroquel 125 milligrams by mouth at bedtime and non-pharmacological interventions. The consult further documented follow up should occur in 3 months and as needed, and staff was to monitor mood and behavior and document accordingly.The Psychiatric Comprehensive Consult dated 12/29/2025 documented Resident #425 was seen for follow up assessment for psychiatric evaluation and medication management and resident was alert, awake, not doing well on current medication, noted to be irritable with disorganized behaviors. The consult also documented staff reported poor sleep and medications would be adjusted. Start Trazodone 25 milligrams by mouth every 12 hours, increase Seroquel to 150 milligrams by mouth at bedtime, and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-pharmacological interventions. The consult further documented follow up should occur in 3 months and as needed, and staff was to monitor mood and behavior and document accordingly. There was no documented evidence comprehensive care plans for Resident #425 reflected monitoring for effectiveness of medication or monitoring of mood or behavior problems and was revised after medications were adjusted.On 03/12/2026 at 12:33 PM, Registered Nurse #1 was interviewed and stated Resident #425 was admitted from the hospital in September 2025 with Seroquel 150milligrams at bedtime, which was continued by the psychiatrist on 09/26/2025, and on 11/07/2025, it was reduced to Seroquel 125 milligrams for major depressive disorder/adjustment disorder. Registered Nurse #1 also stated that they were not on duty when Resident's medication was reduced and could not explain why the reduction was not documented and updated in the resident's care plan when the medication was decreased.On 03/13/2026 at 12:58 PM, the Director of Nursing was interviewed and stated that the Registered Nurse and the supervisors are expected to review and update the residents' comprehensive care plans whenever there is any change in residents' conditions. The Director of Nursing also stated that they noticed that there have been some challenges with residents' comprehensive care plans, and there is on-going review of residents' comprehensive care plans by interdisciplinary committee members to ensure that all necessary care plans are in place and appropriately reviewed. 10 New York Code, Rules and Regulations 415.11(c)(2)(i-iii).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of Residents sampled: 5Number of Residents cited: 1 Based on observation, record review, and interviews, the facility failed to ensure a resident received adequate supervision to prevent an accident. This was evident for one (1) of five (5) residents (Resident #269) reviewed for Accidents out of 38 sampled residents. Specifically, Resident #269 was provided with one person assistance instead of two-person assistance during care on 09/12/2025. Certified Nursing Assistant #4 attempted to turn Resident #269 onto their right side at which time Resident #269 rolled off the bed sustaining a left parietal (area in the skull) hematoma (a collection of clotted blood outside a blood vessel that may occur due to injury or disease) with a laceration and right upper face skin excoriation (damage to the surface of the skin). The findings include:The facility policy titled Accident-Incidents last revised 06/02/2024 stated it is the policy of the facility to monitor and evaluate all the occurrences of accidents or incidents or adverse events occurring on the facility's premises which is not consistent with the routine operation of the facility or care of the residents. These occurrences must be evaluated and investigated. The team will review the investigation, and continue, if necessary, discuss and determine from the investigation the root causes, make recommendations for additional intervention, education and conclude the investigation.Resident #269 was admitted with diagnoses that included Hemiplegia (one-sided paralysis or weakness), Aphasia (a language condition that affects a person's ability to communicate), and Diabetes Mellitus.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #269 was moderately cognitively impaired, had impairment on one side of upper extremity and impairment on both sides of lower extremities. The Minimum Data Set assessment also documented that Resident #269 was dependent on staff for toileting, upper and lower body dressing, required substantial assistance of staff for rolling left and right, and was frequently incontinent of bowel and bladder. The Visual/Bedside Kardex Report dated 08/28/2025, 09/04/2025, 09/11/2025 and 09/12/2025 documented substantial assist of one staff for rolling left/right. The Nursing Progress note dated 09/12/2025 documented that nursing became aware of fall incident on 09/12/2025 at 5:20 PM. Upon arrival Resident #269 was found on the floor face down, noted with left parietal hematoma with laceration and right upper face skin excoriation, with Certified Nursing Assistant #4 by Resident #269's side. The note also documented Certified Nursing Assistant #4, stated that while care was being given to Resident #269, Certified Nursing Assistant #4 was attempting to turn Resident #269 to the right side. Resident #269 attempted to hold on to the metal part of the bed with their left side. However Resident #269 reached out too far and accidentally rolled off the bed on to the floor headfirst. The Physical Therapy PT Therapy Progress Report form dated 08/15/2025 documented rolling left/right in bed as of 07/30/2025 and 08/15/2025 was total dependence without attempts to initiate.The Physical Therapy PT Recert, Progress Report & Updated Therapy Plan dated 08/25/2025 documented rolling left/right in bed, with a baseline date 7/28/2025 and previous date 8/13/2025, was total dependence with attempts to initiate. The section of the form titled Comments documented Resident #269 is able to initiate rolling but requires at least two persons in order to complete rolling. The form also documented Resident #269 will continue to benefit from verbal cues for task sequencing to prevent falls and injury.The Physical Therapy PT Therapy Progress Report form dated 09/04/2025 Physical therapy progress report documented with rolling left/right in bed, with a baseline date of 7/28/2025, previous date of 8/22/2025, and current date of 9/4/2025, was total dependence with attempts to initiate. The section of the form titled Comments documented that Resident #269 is able to initiate rolling but requires at least two persons in order to complete rolling. The form also documented continued use of verbal cues for task sequencing is recommended to reduce the risk of falls and injury.On 03/08/2026 at 12:02 PM, Resident #269's sibling was interviewed and stated that Resident #269 had a fall last year in which (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they were dropped from the bed as one staff was assisting with care at that time instead of two. On 03/08/2026 at 12:24 PM, the Complainant was interviewed and stated Resident #269 has history of multiple strokes, is paralyzed from the waist down, and has limited mobility in the left arm and left leg. The Complainant also stated that on 09/12/2025 as Resident #269 was being changed, they received one person assistance instead of two-person assistance and Certified Nursing Assistant was in the process of changing Resident #269 and attempted to turn Resident #269 during care, at which time Resident #269 ended up getting flipped off the bed. The Complainant further stated that this issue of only one (1) staff assistance instead of two (2) staff assistance during care was addressed previously with the facility. Complainant stated that they along with resident's sibling had previously informed the facility that Resident #269 needed two (2) person assistance for care prior to the fall.On 03/11/2026 at 10:30 AM, Occupational Therapist #1 was interviewed and stated Resident #269 was on a course of physical therapy and occupational therapy from 07/28/2025 to 09/17/2025. Occupational Therapist #1 also stated that when a resident is on therapy, there is an ongoing communication between the Rehabilitation department and the nursing manager and staff on the floor throughout the course of therapy. Occupational Therapist #1 further stated that as per the therapy progress report, rolling to the left/right as of 09/04/2025 required two (2) person assistance to ensure safety, which should have been carried over as it posed a safety and fall risk.On 03/11/2026 at 12:23 PM, the Director of Nursing Services was interviewed and stated that this incident was previously investigated, and Resident #269 was noted to be one person assistance for bed mobility so there was no care plan violation at that time. The State Surveyor then reviewed the physical therapy progress notes dated 09/04/2025 which included the comment that Resident #269 requires at least two persons in order to complete rolling with the Director of Nursing Services. The Director of Nursing Services stated they would have to review this and could not offer an explanation at this time as to why that recommendation was not followed.On 03/12/2026 at 11:26 AM, a follow-up interview was conducted with the Director of Nursing Services who stated the mechanism for communicating between disciplines at the time of incident was via a hard copy document that was passed from the therapist to the nursing manager who would update the resident tasks. The Director of Nursing Services also stated they had reviewed the record and could only locate a note from Rehabilitation to nursing in May 2025 recommending a change from two person assistance to one person assistance and could locate no additional documentation of any other subsequent change. The Director of Nursing Services further stated they were not sure if a change was even done as there was nothing uploaded in the chart and a hard copy could not be located. The Director of Nursing services stated the process was changed in the electronic medical record to allow therapists to directly update tasks. The Director of Nursing Services could not offer an explanation as to what happened with the communication between therapists and nursing staff when Resident #269 was identified as needing two person assistance to complete rolling from left to right and right to left. The Director of Nursing Services further stated that it is important recommendations are carried over because the level of care provided is based on the residents needs and it is important to avoid situations in which accidents happen as in this case Resident #269 fell about a week later.On 03/12/2026 at 3:47 PM, the Director of Rehabilitation was interviewed and stated that as of January 2026, there was a change in the system where therapists can directly enter tasks. The Director of Rehabilitation also stated that prior to that, the Rehabilitation department would pass a slip of paper to inform the nurse managers of the resident's status, and the tasks would then be placed based on the therapist recommendation and the nursing managers assessment. The Director of Rehabilitation further stated that the section that states rolling left assesses residents' ability to roll from left to right and from right to left. The therapy note stated that Resident 269 is in need of two (2) person assistance for rolling was current as of 09/04/2025 and the level of assistance should have been conveyed from Rehabilitation to nursing at that time. The Director of Rehabilitation stated that the task which stated one person assistance for rolling left/right should have been updated to two person assistance at that time even (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335445	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Triboro Center for Rehabilitation and Nursing	1160 Teller Ave Bronx, NY 10456

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	though Resident #269 was not yet discharged from the therapy program. The Director of Rehabilitation also stated they are not sure what happened in the process and could not say if nursing was made aware or if the recommendation went unheeded. The Director of Rehabilitation further stated that there was no documented evidence to show what occurred during that time.On 03/13/2026 at 12:04 PM, the Assistant Director of Nursing #2 was interviewed and stated that the Resident Task list can be updated during the course of therapy if a decline is noted. The Assistant Director of Nursing #2 also stated that if a decline is noted, nursing should be notified and tasks updated accordingly as if it is not properly addressed or picked up in a timely manner, a delay in treatment could occur. 10 New York Code, Rules and Regulations 415.12 (h)(2)