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	05/05/2026

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 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during survey, the facility failed to ensure that residents are free from resident-to-resident abuse. This was evident for two (2) out of five (5) residents (Resident #1 and Resident #2) sampled. Specifically, on 04/17/2026 at 2:30 PM, Resident #1 unscrewed the handle from a mechanical lift and used it to strike Resident #2 on the left side of the head. Resident #2 was assessed and observed with a four (4)-centimeter raised area to the left side of the head as well as a 0.4-centimeter open area on the pad of the left index finger. Emergency Medical Services (911) was called and Resident #2 was transferred to the emergency room for evaluation and returned to the facility on [DATE]. Resident #1 was transferred to the emergency room for psychiatric evaluation and returned to the facility with no new orders. Resident #1 and Resident #2 were placed on separate floors. This resulted in actual harm to Resident #2 that was not Immediate Jeopardy.The findings are: The facility's policy titled Behavior-Resident to Resident Altercation, dated 07/2020 documented it is the policy of the facility to provide the highest quality of care to our residents, by providing staff with the most efficient, resident-centered procedures for the care of our residents per Federal and State Regulations. This includes, but is not limited to, Resident-to-Resident altercations including all forms of abuse, including resident-to-resident abuse must be reported immediately to the Nursing Supervisor, the Director of Nursing Services and the Administrator. The facility's Policy titled, Abuse, dated 07/18/2025 documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. The facility prohibits any exploitation of the mentally and physically disabled residents in the facility. The facility has designed and implemented processes which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property.Resident #1 was admitted to the facility with diagnoses of major depressive disorder, anxiety and acquired absence of the left leg above knee (surgical removal of the leg).The Minimum Data Set (a resident assessment tool) dated 03/20/2026, documented Resident #1 has moderately impaired cognition. Resident #1 uses wheelchair to move around. A review of the Comprehensive Care Plan for Resident-to-Resident Altercation dated 12/03/2025, documented interventions that included administer medication as ordered, monitor behavior and document. Notify medical doctor of inappropriate behavior. Resident-to Resident Care Plan for Altercation was updated on 04/17/2026 to include room change to private room on different floor and offer diversional activity to deter residents.A nursing progress note dated 04/17/2026 at 4:32 PM by Assistant Director of Nursing #1, documented called to the unit to intervene in resident-to-resident altercation. Staff members reported that Resident #1 hit Resident #2 with a metal object in the head. Resident #1 reported that they thought Resident #2 was going through their stuff that is why they hit Resident #2.Resident #1 was transferred to the hospital for psychiatric evaluation and returned with no new orders. Review of a psychiatric progress note dated 04/23/2026 at 5:45 PM, documented Resident #1 seen at bedside for psychiatric re-evaluation and medication management after an altercation with roommate. Will (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	consider adjusting their psychotropic medication. The facility's investigation dated 04/17/2026, documented on 04/17/2026 at 2:30 PM Resident #1 struck Resident #2 on the left side of the head with the handle from the mechanical lift which they unscrewed. Resident #2 sustained a four (4)-centimeter raised area to the left side of the head as well as a 0.4-centimeter open area to the pad of the left index finger. Staff members intervened and separated both residents. Local law enforcement was called and responded. Resident #1 and Resident #2 were transferred to the hospital for evaluation and returned to the facility. Resident #1 (aggressor) was transferred to another unit in a private room. Resident #2Resident #2 was admitted to the facility with diagnoses of diabetes (high level of sugar in the blood), chronic obstructive pulmonary disease (damaged lung with poor air flow), and benign prostatic hyperplasia (enlarged prostate gland).A Minimum Data Set, dated [DATE], documented Resident #2 has intact cognition. Resident #2 uses a wheelchair to move around. A review of the Comprehensive Care plan for Resident-to-Resident Altercation dated 04/17/2026 documented interventions that included monitor behavior and document, psychosocial support and separate resident from the aggressor. A review of the Comprehensive Care plan for Impaired Skin Integrity Abrasion, bruise to head dated 04/28/2026, documented interventions that included prevent resident from scratching and keep hands and body parts from excessive moisture, keep fingernails short.Review of the Hospital record dated 04/17/2026, documented Resident #2 reported they were hit on the head by another resident unprovoked. Swelling with minimal bleeding noted to Resident #2's scalp on left side of the head and an injury to left index finger. No sutures were required. A computer tomography (CT) scan dated 04/17/2026 indicated the results were negative for fracture. There was no documented evidence of new orders from the hospital.A review of a nursing progress note dated 04/17/2026 at 3:19 PM by Assistant Director of Nursing #1 documented Resident #2 was noted with a raised area to the left side of their head with moderate amount of bleeding and their left index finger was noted with a small amount of blood and a 0.4-centimeter open area. Resident #2 was transferred to hospital for evaluation. Review of the physician's order dated 04/27/2026 Tramadol Hydrochloride give one tablet by mouth every six hours as needed for pain for two days. Review of a psychiatric progress note dated 04/23/2026 at 5:49 PM, documented Resident #2 was seen at the bedside for a follow-up assessment after Resident #2 had an altercation with their roommate. Resident #2 is alert and awake, doing well, noted to be calm. Denied pain at this time, no flash back of the incident reported. During an interview on 04/28/2026 at 11:28 AM, Resident #1 stated Resident #2 was in their room and kept coming over to their side. Resident #1 stated on 04/17/2026, when they came out their room, they saw the mechanical lift in the alcove. Resident #1 stated they unscrewed the handle of the mechanical lift and used it to hit Resident #2 when Resident #2 came out of their room.During an interview on 04/28/2026 at 10:48 AM, Resident #2 stated on 04/17/2026, when they came out of their room, Resident #1 approached them and hit them several times on their head and their left index finger unprovoked. Resident #2 stated they feel safe now because Resident #1 was removed from the unit and they do not see Resident #1 anymore. During an interview on 04/28/2026 at 10:00 AM, Housekeeper #1 stated on 04/17/2026 at approximately 2:30 PM when they were sitting in the hallway, they heard another staff member say look. Housekeeper #1 stated when they looked up, they observed Resident #1 hitting Resident #2 several times with the handle from the mechanical lift. During interview with Licensed Practical Nurse #1 and Certified Nursing Assistant #1 on 04/28/2026, they stated they were sitting at the nursing station when they heard Housekeeper #1 calling out for help. They stated when they looked down the hallway, they observed Resident #1 hitting Resident #2 with the mechanical lift handle and they immediately separated both residents.During an interview on 04/29/2026 at 10:30 AM, Licensed Mental Health Counselor #1 stated after their session with Resident #2 on 04/17/2026 and on 04/20/2026 there was no evidence of psychosocial harm. Resident #2 stated they were feeling safe in the facility.During an interview on 04/29/2026 at 10:21 AM, Assistant Director of Nursing #1 stated on 04/17/2026 the unit manager notified them about the incident. Assistant Director of Nursing #1 stated they went to the unit and observed Resident #2 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	sitting in their wheelchair outside of their room. Assistant Director of Nursing #1 stated Resident #2 reported that Resident #1 struck them in the head for no reason. Assistant Director of Nursing #1 stated Resident #2 was observed with a raised area to the left side of the head and discoloration to left index finger. Assistant Director of Nursing #1 stated Medical Doctor #1 arrived on the unit and examined Resident #2. Assistant Director of Nursing #1 stated Emergency Medical Services was called and responded along with law enforcement. Assistant Director of Nursing #1 stated both residents were separated and transferred to the hospital.During an interview on 04/30/2026 at 2:46 PM, Medical Director #1 stated on 04/17/2026, they were called regarding an altercation between two of their residents. Medical Doctor #1 stated they went to the unit and Resident #2 was sitting in their wheelchair. Medical Doctor #1 stated Resident #2 reported Resident #1 hit them unprovoked. Medical Doctor #1 stated Resident #2 was observed with some bleeding from their head and swelling on the left side of the head. Medical Doctor #1 stated Resident #2 was transferred to the hospital for computer tomography scan (CT) of the head and the results were negative for fracture. Medical Doctor #1 stated the residents were seen by psychiatry. During an interview on 04/30/2026 at 3:04 PM, the Administrator stated they were notified by the Director of Nursing that there was a resident-to resident altercation and both residents were transferred to the hospital for evaluation. The Administrator stated the incident was reported to the Department of Health and the police were called immediately. The Administrator stated that maintenance checked on all Hoyer lifts (mechanic lift) to ensure that they are in good working condition and that no residents can unscrew or interfere with the mechanical lift. The Administrator stated that all staff were instructed to place the mechanical lift in a locked area. The Administrator stated staff members were re-educated on abuse, neglect and mistreatment and frequent rounding to ensure residents' safety. The Administrator stated Resident #1 was transferred to another unit in a private room. 10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)