STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335506	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronx Center for Rehabilitation & Health Care	1010 Underhill Avenue Bronx, NY 10472

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 a resident was free from physical abuse. This was evident for one out of five residents (Resident #1) sampled. Specifically, on 05/12/2026 at 2:20 PM, Licensed Practical Nurse #1 was called to Resident #1's room and the resident indicated Certified Nursing Assistant #1 hit them after they spit on them (unwitnessed). Certified Nursing Assistant #1 refused to leave the room and continued providing care, and then Resident #1 spat and kicked Certified Nursing Assistant #1 who in turn hit the resident on the right side of the face and covered their mouth with a washcloth. Resident #1 was assessed by Registered Nurse Unit Manager #1 with redness on their right cheek and complaints of pain and was transferred to the emergency room for evaluation on 05/12/2026. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.The findings are: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 resident in the facility. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected of alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property.Resident #1 was admitted to the facility with diagnoses of dementia, anxiety, and major depressive disorder.The Minimum Data Set (a resident assessment tool) dated 04/02/2026, documented Resident #1 had severely impaired cognition and required substantial/maximal assistance (Helper does more than half the effort).A review of the Comprehensive Care Plan for at risk for abuse, neglect, misappropriation, and/or exploitation dated 03/30/2026 documented interventions that included monitor resident for signs/symptoms of abuse, neglect, misappropriation, and/or exploitation and report to facility's abuse officer and medical provider. A review of the Comprehensive Care Plan for behavior symptoms dated 04/10/2026 documented Resident #1 kicks at staff and throws water and other objects at staff. The interventions included determining the cause of the behavior and maintaining resident's safety. Re-approach resident for care/toileting/medication administration/treatments and other needs when resident is more agreeable.A Documentation Survey Report (Accountability Record) dated 05/01/2026 documented that Resident #1 required extensive assistance of one staff for all activities of daily living care. Instructions also are documented for staff to approach the resident in a slow and calm manner and to re-approach resident for care.An Initial Event Documentation by Registered Nurse Supervisor #1, dated 05/12/2026 at 2:20 PM, documented resident abuse allegation report received from Licensed Practical Nurse #1. Resident #1 was assessed with redness to the right side of their face. Resident #1 reported that a black lady hit them, and to get them out of here. Resident #1 was removed from the situation and staff (Certified Nursing Assistant #1) removed from care. Resident #1 denied pain at this time during assessment and no other injury noted. The Director of Nursing, Nurse Practitioner # 1, notified, and 911 called.A Physician's Progress note dated 05/12/2026 documented that Resident #1 was seen and examined for alleged abuse. On assessment, the resident stated that (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335506	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronx Center for Rehabilitation & Health Care	1010 Underhill Avenue Bronx, NY 10472

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	the lady hit them. Resident #1 reported some pain to both sides of the face. Slight facial redness noted. No swelling or bruising. Resident #1 was transferred to the hospital for evaluation due to the nature of the reported incident and ongoing concern for possible injury.The facility's investigation dated 05/12/2026 at 2:20 PM, documented an allegation of staff-to-resident physical abuse involving Resident #1. Licensed Practical Nurse #1 was asked by [NAME] #1 to go to Resident #1's room. The investigation explained that while Certified Nursing Assistant #1 was trying to toilet Resident #1, the resident became agitated, fought and spat on Certified Nursing Assistant #1. Certified Nursing Assistant #1 then hit Resident #1 on the right side of their face and put an incontinent brief around the resident's mouth and nose. Licensed Practical Nurse #1 intervened and asked Certified Nursing Assistant #1 to leave the room while they completed Resident #1's care. Registered Nurse Supervisor #1 and Nurse Practitioner #1 were notified, and a body assessment was done. Resident #1 was observed with redness to their right cheek and was transferred to the hospital for evaluation. 911 was called and responded. The Director of Nursing and the Administrator were notified (time not mentioned). The facility's investigation of the incident concluded there was reasonable cause to believe resident abuse had occurred and Certified Nursing Assistant #1 was suspended pending outcome of the investigation.A review of the hospital discharge record dated 05/12/2026, revealed that a computed tomography scan of Resident #1's head was done. The results revealed no acute intracranial hemorrhage and no acute fracture or dislocation.A Psychology Progress note dated 05/14/2026 at 1:24 PM, documented Resident #1 was seen for allegations of abuse. Resident #1 reported that a staff member hit them on both sides of their face. Resident #1 denied distress and denied fearfulness.During an interview on 05/18/2026 at 10:16 AM, Resident #1 stated that they spit on the lady because they were too rough during care. Resident #1 stated the lady hit them on the right side of the face.During an interview on 05/18/2026 at 1:04 PM, Certified Nursing Assistant #1 stated that on 05/12/2026 at 2:20 PM, they went into Resident #1's room to provide incontinence care and that Resident #1 was calm. Certified Nursing Assistant #1 stated they turned Resident #1 onto their side to wash their back, and the resident began to kick and spit on them. Certified Nursing Assistant #1 stated they put the wet washcloth over Resident #1's mouth and told them to stop spitting. Certified Nursing Assistant #1 stated they did not hit Resident #1. Certified Nursing Assistant #1 stated that this was not the first time they were assigned to Resident #1.Certified Nursing Assistant #1 provided a statement to the facility on [DATE] stating that they gently tapped Resident #1 on their lips and put an incontinent brief in front of Resident #1's mouth.During an interview on 05/18/2026 at 11:00 AM, Licensed Practical Nurse #1 stated they exited the elevator with Nurse Practitioner #1 when [NAME] #1 informed them to go to Resident #1's room. Licensed Practical Nurse #1 stated they arrived at Resident#1's room with Nurse Practitioner #1 when they observed Certified Nursing Assistant #1 providing incontinence care to Resident #1. Licensed Practical Nurse #1 stated they asked what happened and Resident #1 reported that Certified Nursing Assistant #1 was rough during (incontinence) care, and they spat on Certified Nursing Assistant #1 who in turn hit them in the face. Licensed Practical Nurse #1 stated they instructed Certified Nursing Assistant #1 to stop providing care to Resident #1 and to leave the room. However, Certified Nursing Assistant #1 refused to leave Resident #1's room and attempted to continue washing the resident. Licensed Practical Nurse #1 stated they witnessed Resident #1 kick and spit on Certified Nursing Assistant #1. Certified Nursing Assistant #1 then punched Resident #1 in their face and covered the resident's face with the wash towel to prevent them from spitting. Licensed Practical Nurse #1 stated they pulled Certified Nursing Assistant #1 away from Resident #1 and took over washing the resident. Licensed Practical Nurse #1 stated Resident #1's face was red. Licensed Practical Nurse #1 stated they asked Nurse Practitioner #1 at 2:33 PM, to call Registered Nurse Unit Manager #1 to come as they did not see anyone in the hallway (CNAs were in other residents' rooms). Licensed Practical Nurse #1 stated that Certified Nursing Assistant #1 sat on a chair in Resident #1's room and was in their full view until they saw Registered Nurse Unit Manager #1, then Certified Nursing Assistant #1 was removed from the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335506	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bronx Center for Rehabilitation & Health Care	1010 Underhill Avenue Bronx, NY 10472

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	During an interview on 05/18/2026 at 10:30 AM, Registered Nurse Unit Manager #1 stated they were informed by Licensed Practical Nurse #1 that Certified Nursing Assistant #1 hit Resident #1 in their face, and they reported the incident to the Director of Nursing at 2:35 PM on 05/12/2026. Registered Nurse Unit Manager #1 stated they performed a body assessment and Resident #1 was observed with redness on the right side of their face, complaints of pain to the right side of their face and Tylenol (650 milligram) was administered. Registered Nurse Unit Manager #1 stated that they reported the incident to Nurse Practitioner #1 who ordered Resident #1 be transferred to the hospital for evaluation.During an interview on 05/18/2026 at 12:22 PM, Director of Nursing #1 stated they were informed by Registered Nurse Unit Manager #1 at 2:35 PM (on 05/12/2026) that Certified Nursing Assistant #1 hit Resident #1 in their face. Director of Nursing #1 stated Certified Nursing Assistant #1 was with Resident #1 between 2:20 PM - 2:30 PM (on 05/12/2026) less than 10 minutes. Director of Nursing #1 stated Licensed Practical Nurse #1 entered Resident #1's room approximately 2:25 PM and instructed Certified Nursing Assistant #1 to leave the room and they took over the care of Resident #1. Director of Nursing #1 stated Certified Nursing Assistant #1 was removed from resident's care and was suspended pending the outcome of the investigation. Director of Nursing #1 stated that Certified Nursing Assistant #1 never returned to work and has retired from the facility. Director of Nursing #1 stated they investigated the incident and concluded that resident abuse had occurred.During an interview on 05/18/2026 at 1:24 PM, Nurse Practitioner #1 stated they went to Resident #1's room with Licensed Practical Nurse #1 and observed Certified Nursing Assistant #1 providing incontinence care to Resident #1. Nurse Practitioner #1 stated that Certified Nursing Assistant #1 reported that Resident #1 spit on them. Nurse Practitioner #1 stated that Licensed Practical Nurse #1 took over caring for Resident #1 and they left the room to attend to another resident who was distressed. Nurse Practitioner #1 stated they heard Licensed Practical Nurse #1 calling for them and when they went to Resident #1's room, Licensed Practical Nurse #1 asked them to call Registered Nurse Unit Manager #1 because Resident #1 reported Certified Nursing Assistant #1 was rough and hit them. Nurse Practitioner #1 stated that they called Registered Nurse Unit Manager #1, and they also assessed Resident #1 and observed redness to the right side of the resident's face. Nurse Practitioner #1 stated Resident #1 complained of pain to the right side of their face during their assessment. Nurse Practitioner #1 stated Resident #1 was sent to the hospital for evaluation.During an interview on 05/19/2026 at 10:11 AM, the Administrator stated they became aware of the incident on 05/12/2026 within 15 minutes of the incident. The Administrator stated that the Director of Nursing brought Certified Nursing Assistant #1 and their union delegate to their office and Certified Nursing Assistant #1 reported that Resident #1 spit at them and hit their arm and they reacted and hit Resident #1 with an open hand on their mouth. The Administrator stated Resident #1 told the Police Officers that nothing happened and that the Officers did not take any report.10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)