STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335621	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Hebrew Geriatric Center	391 Pelham Road New Rochelle, NY 10805

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and observations conducted during an abbreviated (2968858) survey, the facility did not ensure that a resident was free from abuse. This was evident for 1 (Resident #1) of 3 residents sampled for abuse. Specifically, Certified Nursing Assistant #1 is seen in video footage dated 03/26/2026 hitting the back of Resident #1's head.The facility policy #276 for abuse prevention last reviewed January 2025 documented that it was their policy to ensure all residents were free from abuse, neglect, misappropriation of resident property and exploitation. Resident #1 was admitted [DATE] with diagnoses which included unspecified dementia, unspecified severity, with other behavioral disturbance. An admission minimum data set (an assessment tool) dated 11/27/2025 documented the resident had a brief interview of mental status score of 4, indicating severe cognitive impairment. Resident #1 had behaviors of wandering and rejection of care that occur 1 (one) to 3 (three) days and impairment on both sides of the upper and lower extremities. Resident #1 used a wheelchair for locomotion.On 04/09/2026 surveyors reviewed the footage of the video provided by the facility and observed the following:The video dated 26/03/2026 (March 26, 2026) at time stamp 10:58:40 shows Resident #1 in their wheelchair sitting in the main day room area and Certified Nurse Assistant #1 is pushing the wheelchair and seems to be moving other wheelchairs around and then Resident #1 reaches both their arms up over their head and behind them in what appears to be an attempt to touch Certified Nurse Assistant #1, and at time stamp 10:58:44 Certified Nursing Assistant #1 is seen striking the back of the head of Resident #1.Review of the investigative summary dated 03/30/2026 documented that on 03/26/2026 at 10:58 am on the video footage Certified Nurse Assistant #1 was observed moving residents in their wheelchairs towards the entrance of the dayroom near the nursing station desk. Resident #1 is in their wheelchair and seemed to be wheeling themselves towards the entrance. Certified Nurse Assistant #1 then appears to be redirecting Resident #1. Certified Nurse Assistant #1 pushed the back of Resident #1's wheelchair towards the nursing station. Resident #1 appeared to have resisted the movement of their wheelchair and reached with both of their hands backward as if trying to reach Certified Nurse Assistant #1. Certified Nurse Assistant #1 leaned backward avoiding the resident's hands and immediately was seen using their right hand to hit the back of Resident #1's head. During an interview on 04/09/2026 at 1:40 PM Environmental Service Worker #1 stated that while mopping the floor they could see into the main day room area and they heard a commotion, and they looked up and they could hear that Certified Nurse Assistant #1 was telling Resident #1 to put your feet up and then they saw Certified Nurse Assistant #1 pop Resident #1 on their head. They asked the nurse that was near them if they saw what occurred, and the nurse stated no. During this interview it was revealed that there was no further discussion between Environmental Service Worker #1 and the nurse, and Environmental Service Worker #1 did not report this incident to anyone else in the facility until Monday morning 03/30/2026, when they informed the Director of Nursing. During an interview on 04/10/2026 at 3:13pm the Director of Nursing confirmed that they were informed by Environmental Service Worker #1 on Monday 03/30/2026 of the incident that occurred several days prior on 02/26/2026. They further stated that (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they then reviewed the staffing for the day in question and determined that the staff member was currently working on the unit. The Director of Nursing had a staff member tell Certified Nurse Assistant #1 to leave the unit and report to the office, and they informed Certified Nurse Assistant #1 that they were being suspended pending further investigation. The Director of Nursing and other administrative staff reviewed the video footage from the date and time that was provided by Environmental Service Worker #1, and they saw that Certified Nurse Assistant #1 hit Resident #1 on the back of their head. NYCRR 415.4(b)(1)(i)

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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 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. Based on observation, record review, and interviews conducted during an abbreviated survey (2968858), the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or 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, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and law enforcement) in accordance with State law through established procedures. This was evident in one out of three residents reviewed for abuse (Resident #1). Specifically, an alleged incident of abuse involving Resident #1 was reported to facility staff on 03/26/2026 and the facility did not report the allegation of abuse to the Department of Health or law enforcement until 03/30/2026.Review of the facility's abuse prevention and reporting policy #276 last reviewed/revised 1/2025 documented on page 10 that it was the policy of the facility that abuse allegations are reported per Federal and State Law. Allegations will be reported within required timeframes to the NYSDOH. Further breakdown of the policy noted under letter d) indicated when should abuse be reported, immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury. On page 13 the policy further documented under subheading staff-resident abuse, that all allegations/occurrences of all types of staff-to-resident abuse must be reported to the Administrator and to other officials.Resident # 1 was admitted to the facility on 11/2025 with diagnoses that included, but were not limited to, dementia with other behavioral disturbances, hypertension, and chronic kidney disease. An admission minimum data set (an assessment tool) dated 11/27/2025 documented the resident had a brief interview of mental status score of 4, indicating severe cognitive impairment. Resident #1 had behaviors of wandering and rejection of care that occur 1 to 3 days per week and impairment on both sides of the upper and lower extremities. Resident # 1 used a wheelchair for locomotion.On 04/09/2026 surveyors reviewed the footage of the video provided by the facility and observed the following:Video dated 26/03/2026 (March 26, 2026) at time stamp 10:58:40 Resident #1 is in their wheelchair sitting in the main day room area and Certified Nurse Assistant #1 is pushing the wheelchair and seems to be moving other wheelchairs around and then Resident #1 reaches both their arms up over their head and behind them in what appears to be an attempt to touch Certified Nurse Assistant #1, and at time stamp 10:58:44 Certified Nursing Assistant #1 is seen striking the back of the head of Resident #1.Review of the investigative summary dated 03/30/2026 documented that on 03/26/2026 at 10:58 am on the video footage Certified Nurse Assistant #1 was observed moving residents in their wheelchairs towards the entrance of the dayroom near the nursing station desk. Resident #1 is in their wheelchair and seemed to be wheeling themself towards the entrance. Certified Nurse Assistant #1 then appears to be redirecting Resident #1. Certified Nurse Assistant #1 pushed the back of Resident #1's wheelchair towards the nursing station. Resident #1 appeared to have resisted the movement of their wheelchair and reached with both of their hands backward as if trying to reach Certified Nurse Assistant #1. Certified Nurse Assistant #1 leaned backward avoiding Resident #1's hands and immediately was seen using their right hand to hit the back of Resident #1's head. Review of the staffing schedule for Certified Nurse Assistant #1 revealed that they worked the day shift (7:00am to 3:00pm) on 03/26/2026 and returned for their next scheduled day shift on 03/30/2026 and they worked on that day until they were notified by the Director of Nursing that they were suspended pending further investigation. During an interview on 04/09/2026 at 1:40 PM Environmental Service Worker #1 stated that while mopping the floor they could see into the main day room area and they heard a commotion, and they looked up and they could hear that Certified Nurse Assistant #1 was telling Resident #1 to put your feet up and then they saw Certified Nurse Assistant #1 pop Resident #1 on their head. They asked the nurse, subsequently (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified as Licensed Practical Nurse #1, that was near them, if they saw what occurred, and the nurse stated no. During this interview it was revealed that there was not much more discussion, and Environmental Service Worker #1 did not report this incident to anyone else in the facility until Monday 03/30/2026, when they arrived in the morning and informed the Director of Nursing. During an interview on 04/09/2026 at 3:00 PM Licensed Practical Nurse #1 stated that Resident #1 is mainly Spanish speaking and that when they first came to the unit, they were quiet, but after some time there have been some changes. Licensed Practical Nurse #1 stated Resident #1 is now speaking Spanish more, has behaviors where they are wheeling around and getting up and going even though they are unstable, they have had falls, and they get mad when you redirect them. Licensed Practical Nurse #1 stated that Resident #1 does not like the noise in the day room and they get angry and very mad about noise. Licensed Practical Nurse #1 stated that on the day in question Environmental Service Worker #1 was talking and then they said hey did you see that person hit Resident #1. Licensed Practical Nurse #1 stated that they understood that Certified Nurse Assistant #1 and Environmental Service Worker #1 were not on good terms with each other. Licensed Practical Nurse #1 stated that knowing that caused them to doubt what they were told and affected their response. Licensed Practical Nurse #1 stated that they know that even if they do not believe something they are supposed to report, I did not report that is my failure. Licensed Practical Nurse #1 stated that they are not aware of any other residents ever complaining about the care they received from Certified Nurse Assistant #1.During an interview on 04/10/2026 at 3:13 PM the Director of Nursing confirmed that they were informed by Environmental Service Worker #1 on Monday 03/30/2026 of the incident that occurred several days prior on 03/26/2026. They further stated that they then reviewed the staffing for the day in question and determined that Certified Nurse Assistant #1 as currently working on the unit. The Director of Nursing had a staff member tell Certified Nurse Assistant #1 to leave the unit and report to the office, and they (the Director of Nursing) informed Certified Nurse Assistant #1 that they were being suspended pending further investigation. The Director of Nursing and other administrative staff reviewed the video footage from the date and time that was provided by Environmental Service Worker #1, and they saw that Certified Nurse Assistant #1 hit Resident #1 on the back of their head. NYCRR 415.4 (b)(2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, and interviews during an abbreviated survey (2968858), the facility did not ensure a comprehensive care plan was developed and implemented to maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (1) of three (3) residents reviewed for abuse. Specifically, Resident #1 had severe cognitive impairment and was involved in a documented incident on 03/26/2026 where abuse occurred and an abuse care plan was not initiated. Review of the facility policy #2-214 comprehensive person-centered care plan dated 1/2023 documented that a comprehensive person-centered care plan is developed for each resident to include measurable goals, objectives and timeframe to meet the resident's medical, nursing, rehabilitation, psycho-social, cultural and nutritional needs. These needs are identified from the IDC (interdisciplinary care) team assessment.Review of the facility's abuse prevention and reporting policy dated 2/2016 and reviewed/revised 1/2025 documented the interdisciplinary team identifies resident risk factors and plans for protecting resident's rights as part of the individualized, comprehensive care planning process. On going assessment, care planning for appropriate intervention and monitoring of resident's needs and behaviors which might lead to conflict, or neglect are conducted. A care plan must be developed to meet the residents' needs and behavioral symptoms and implement measures to protect the alleged victims and others.Resident #1 was admitted to the facility on 11/2025 with diagnoses that included, but were not limited to, dementia with other behavioral disturbances, hypertension, and chronic kidney disease.An admission minimum data set (an assessment tool) dated 11/27/2025 documented Resident #1 had a brief interview of mental status score of 4, indicating severe cognitive impairment. Resident #1 had behaviors of wandering and rejection of care that occurred 1 to 3 days a week and impairment on both sides of the upper and lower extremities. Resident #1 used a wheelchair for locomotion.Review of facility's investigative summary dated 03/30/2026 documented on 03/26/2026 at 10:58 am on the video footage, Certified Nurse Aide #1 was observed moving residents in their wheelchairs towards the entrance of the dayroom near the nurse's station desk. Resident #1 was in their wheelchair seen wheeling themself towards the entrance. Certified Nurse Aide #1 appeared to be redirecting Resident #1. Certified Nurse Aide #1 pushed the back of Resident #1's wheelchair toward the nurse's station. Resident #1 appeared to have resisted the movements of their wheelchair and reached with both hands backward as if trying to reach Certified Nurse Aide #1. Certified Nurse Aide #1 leaned backward avoiding the residents' hands and immediately was seen using their hand to hit the back of Resident #1's head. A Review of Resident #1's care plans did not include documented evidence of an abuse care plan for Resident #1 after the incident on 03/26/2026.During an interview with Unit Manager #1 on 04/10/2026 at 12:58pm they stated Resident #1 is Spanish speaking and understands simple English. One of their triggers is to leave the day room to go to the bathroom. It is not easy for someone in the day room to assist with toileting them because they are watching the whole group in the day room. They have not observed Resident #1 to be physically aggressive, but they do hear them raise their voice when they want to leave the dayroom. Resident #1 does have a behavior care plan with interventions that include quiet areas to express needs and to resolve behavior issues, redirection, toileting scheduled every 2-4 hours and as requested, diversional mobility, recreation therapy, and they will call the son if the resident is having behaviors. The resident is on weekly behavioral notes. There should be an abuse care plan put in place after an incident. There was an update to the behavior care plan after the incident to reflect an added intervention, but other than that they did not see anything else. They do not know of any other residents in the facility having an abuse care plan. This was the first time they had an issue with abuse in the facility. Unit Manager #1 stated they can see where not having an abuse care plan could be an issue.During an interview with the Director of Nursing on 04/10/2026 at 3:12pm they stated in nursing it is the Registered Nurse that initiates, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updates, and revises the care plan, such as, on admission, when there is significant change, episodes, with minimum data set assessments that trigger, and following quarterly and annual assessments. Director of Nursing stated that in the facility's historical records they found that a risk for abuse care plan was initiated after incidents, and since identifying that, Registered Nurse #1 initiated a risk for abuse care plan for Resident #1. Director of Nursing also stated that residents with dementia and combative behaviors can be at higher risk for abuse. NYCRR 415.11(c)(1)