STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335063	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coler Rehabilitation and Nursing Care Center	900 Main St Roosevelt Island, NY 10044

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907 Based on record review and interviews during an abbreviated survey (NY00318982, NY00315258), the facility failed to protect a resident's right to be free from physical restraint. This was evident in 1 (Resident #2) of 3 residents reviewed for abuse. Specifically, on 06/26/2023 during medication administration, Registered Nurse #3 held Resident #2's right arm firmly as they disconnected the syringe from the gastric tube. Resident #2 sustained a scratch mark on the right hand. The findings are: The facility's Policy and Procedure titled Abuse Prevention and Reporting and Management of other reportable incidents with a revised date of 11/01/2022 documented that facility residents have the right to freedom from verbal, sexual, physical, and mental abuse, corporal punishment, neglect, exploitation, mistreatment, involuntary seclusion and from misappropriation of their property and other crimes. The facility's Policy and Procedure titled Use of Restraints with a revised date of 12/23/2019 documented restraints shall only be used to treat resident's medical symptoms and never for discipline or staff convenience or for the prevention of fall. The policy defined physical restraints as any manual method attached or adjacent to a resident's body that an individual cannot remove easily which restricts freedom of movement or restricts normal access to one's body. Resident #2 was admitted to the facility with diagnoses of Epilepsy, Traumatic Brain Injury, and Chronic Respiratory Failure. The Minimum Data Set, dated dated dated [DATE] documented that Resident #2 had moderate impairment in cognition. The Minimum Data Set documented Resident #2 had a feeding tube. A Plan of Care Note dated 06/26/2023 at 4:53 pm documented Resident #2 pulled their gastric tube. Resident was calm and cooperative during gastric tube insertion by the physician. The note documented Resident #2 stated that the medication nurse tied them after they said no to medication. Resident #2 was noted with a faint discoloration on the right arm. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician progress note dated 06/26/2023 at 11:20 am documented Resident #2 pulled their gastric tube and was reinserted. Resident #2 claimed they did not want to take their medications and the nurse gave medications by holding their wrist. The physician note documented a faint scratch mark on the right hand during examination. The facility's Accident/Incident report dated 06/26/2023 documented Resident #2 stated that the nurse came to their room to give them unnecessary medication, Resident #2 refused but the nurse insisted. The nurse took a plastic bag, rolled it up, tied their arm to the bedrail and gave Resident #2 the medication. The written statement by Registered Nurse #3 dated 06/26/2023 documented after administering Resident #2's medication and while the gastric tube syringe was still attached to Resident #2's gastric tube, Resident #2 swung their right arm and hit Registered Nurse #3 forcefully. This prompted Registered Nurse #3 to hold Resident #2's right arm down firmly until they were able to disconnect the syringe from the feeding tube. The Risk Management Summary Report documented the incident date as 06/26/2023, investigation completion date of 07/03/2023. The report documented the Risk Manager interviewed the accused nurse and the nurse stated that after administering the medications through Resident #2's gastric tube, the Resident struck the nurse on their arm. To prevent the Resident from striking the nurse again, the nurse took a plastic bag from their pocket and placed it on the resident's arm and held the arm firmly as they disconnected the syringe from the gastric tube. During an interview on 10/03/2023 at 1:21 pm, Resident #2 stated they did not remember the nurse's name, but the nurse twisted up a plastic bag and tied their arm to the rail. Resident #2 stated that the nurse tied them because Resident #2 was refusing their medication. During an interview on 10/06/2023 at 2:40 pm, Registered Nurse #3 stated they administered morning medication via gastrostomy tube to Resident #2 when the Resident hit them while the syringe was still attached to the gastrostomy tube. Registered Nurse #3 stated they held Resident #2's right hand down to protect themselves and Resident #2. Registered Nurse #3 stated they had a bag in their pocket when they entered Resident #2's room but they did not use the bag to tie Resident #2. During an interview on 10/18/23 at 12:19 pm, Risk Manager #1 stated that Registered Nurse #3 mentioned in their interview that they used a bag to hold onto Resident #2's arm. Risk Manager #1 stated they concluded that abuse was undetermined because there was not enough evidence to support the allegation and there was no witness. During an interview on 01/18/2024 at 1:43 pm, the Administrator stated they were made aware of the abuse allegation and that the outcome of the investigation was not substantiated because the incident was not observed. 10 NYCRR 415.4(a)(2-7)

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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** 39365 Based on record review and interviews during an Abbreviated Survey (NY00315258, NY00318982), the facility failed to ensure that a resident's care plan was reviewed and revised by the interdisciplinary team following an allegation of abuse. This was evident in 1 (Resident #1) of 3 residents reviewed for abuse. Specifically, on 04/21/2023, Resident #1 alleged that Food Service Aide #1 hit their leg with a food truck. Resident #1's Comprehensive Care Plan was not reviewed and revised to reflect the allegation. The findings are: The facility's Policy and Procedure titled: Abuse Prevention and Reporting and Management of other reportable incidents with a revised date of 11/01/2022 documented that every resident of the facility is assessed by the interdisciplinary team for risk of abuse or for a risk of abusing others. This assessment is conducted upon admission, quarterly, and annually; or as indicated by a change in resident's status or behavior. Following assessment, the team develops an individualized abuse care plan based on the assessment findings. In the event of an incident of abuse, the team reviews, revises, and updates the care plan on the basis of the abuse incident. The facility's Policy and Procedure titled Care Plans, Comprehensive Person-Centered with a revised date of 12/2016, documented that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. Resident #1 was admitted to the facility with diagnoses of Paraplegia, Chronic Pain, and Diabetes Mellitus. The Minimum Data Set, dated dated dated [DATE] documented that Resident #1 was cognitively intact. A nurse's note by Registered Nurse #1 dated 04/21/2023 at 8:44 PM documented at around 5:15 pm, Resident #1 stated they asked Food Service Aide #1 not to leave their food tray by the window, but they did it anyway. Resident #1 stated they approached Food Service Aide #1 to talk to them and Food Service Aide #1 ran them over with the food cart causing their wheelchair and leg to collide with the food cart. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Risk Management Summary Report documented the incident occurred on 04/21/2023, investigation completion date of 04/26/2023. The investigative findings documented that Registered Nurse #1 heard Resident #1 yelling and cursing at Food Service Aide #1. Resident #1 was blocking Food Service Aide #1 from removing the food truck from the unit. Resident # stated that Food Service Aide #1 left their food tray by the window. When they approached Food Service Aide #1 to talk, Food Service Aide #1 ran them over with the food truck striking their leg and their wheelchair. Food Service Aide #1 documented in their statement that they placed Resident #1's food tray on the heater after asking Resident #1 twice where to place it. Resident #1 became agitated and pursued Food Service Aide #1 on their wheelchair, threatened to strike the Food Service Aide, and blocked the food truck with their motorized wheelchair. Food Service Aide #1 asked Resident #1 to make way for them to exit, but Resident #1 banged their wheelchair into the food truck. A Certified Nursing Assistant witnessed the incident. The facility concluded that the available evidence did not support the allegation of staff to resident abuse. A Comprehensive Care Plan for at risk for being abused and at risk of verbal/physical/sexual abuse by others related to diagnosis of paraplegia and self-care deficit was initiated on 12/18/2019. There was no documented evidence that care plan was reviewed after the alleged incident on 04/21/2023. A Comprehensive Care Plan for Behavior was initiated on 12/21/2019. The care plan documented that Resident #1 had behavior problem related to diagnosis of personality disorder and verbal and physical abuse with others. There was no documented evidence that the care plan was reviewed after the alleged incident on 04/21/2023. During an interview on 10/05/2023 at 12:11 PM, Registered Nurse #1 stated it was not their responsibility to update a care plan after the incident on 04/21/2023. It was the Head Nurse's responsibility to update the care plan. During an interview on 10/05/2023 at 1:30 PM, Registered Nurse #2 stated that whoever initiated the incident report was supposed to review and update the care plan. Registered Nurse #2 stated Registered Nurse #1 should have reviewed and revised Resident #1's care plan after the alleged incident on 04/21/2023. During an interview on 10/04/2023 at 11:30 AM, the Deputy Director of Nursing stated that the Staff Nurse or Head Nurse on the unit is responsible for reviewing the Comprehensive Care Plan. The Staff Nurse should put a new intervention after each incident to prevent recurrence. The Deputy Director of Nursing stated the Assistant Director of Nursing is responsible for overseeing the care planning and updating of interventions. During an interview on 01/18/2024 at 12:30 PM, the Director of Nursing stated that when an incident happens, the Registered Nurse is supposed to update the Comprehensive Care Plan with new interventions. When there is an allegation of abuse, the care plan on abuse is supposed to be reviewed and updated. The Director of Nursing stated that if the incident was related to resident's behavior, the behavior care plan must be reviewed and updated. The Director of Nursing stated that it was the Assistant Director of Nursing's responsibility to ensure that Resident #1's Comprehensive Care Plan was reviewed and interventions revised after the incident on 04/21/2023, which was not done. 10 NYCRR 415.11(c)(2)(i-iii)