

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/01/2025
NAME OF PROVIDER OR SUPPLIER  Coler Rehabilitation and Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 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.  (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview conducted during the abbreviated survey (# 2619467), the facility did not ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was 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 New York State Department of Health. This was evident for one (1) of three (3) residents (Resident #1) sampled. Specifically, on 09/09/2025 at 7:30 AM, Resident #1 had an unwitnessed fall and sustained a left femoral fracture (break in bone of the upper leg between the hip and knee) which the facility did not report to the New York State Department of Health until 09/16/2025 at 02:54 PM. The findings are: The facility policy titled 'Abuse Prevention and Reporting and Management of Other Reportable Incidents' dated 11/01/2022 documented Risk Management is responsible for assessing and ensuring the reporting of eligible incidents per regulatory requirements. The policy also documented federal and state regulations require that all allegations of abuse be reported immediately, but not later than 2 hours if events or allegation resulted in serious bodily injury. Resident #1 had diagnoses including Dementia, Alzheimer's Disease, Hypertension, and Arthritis. A review of the Minimum Data Set (a resident assessment tool) dated 06/11/2025 documented Resident #1 had severe cognitive impairment, and they required supervision when lying to sitting on side of bed, sit to stand and moderate assistive during ambulation. The Facility Report of Investigation dated 09/22/2025 documented Resident #1 was observed on the floor by staff near their bed in pain and holding their left thigh. Resident #1 reported to staff that they rolled off their bed and fell. Resident #1 was sent to the hospital on [DATE] and returned to the facility on [DATE] with a diagnosis of left femoral fracture. The Nurses Note dated 09/15/2025 at 08:50 PM, documented Resident #1 was readmitted to facility from the hospital around 4 PM and was unable to put pressure on their left leg due to closed fracture of the left hip. The New York State Department of Health Nursing Home Facility Incident Report revealed the incident was submitted to the Department of Health on 09/16/2025 at 02:54 PM. On 10/31/2025 at 02:28 PM, an interview was conducted with the Director of Quality Management who stated they reviewed the incident to ensure compliance however, the Director of Risk Management reported the incident to the New York State. The Director of Quality Management also stated Resident #1 was observed on the floor by a Certified Nursing Assistant on 09/09/2025 around 7:30 AM, was complaining of pain and was sent to the hospital for further evaluation. The Director of Quality Management further stated it was only after Resident #1 returned from the hospital that they learned about the fracture. The Director of Quality Management concluded by saying an injury of unknown origin should be reported with 2 (two) hours after the facility was first made aware. On 10/31/2025 at 02:37 PM, an interview was conducted with the Director of Risk Management who stated they are part of the team and other Nursing Supervisors who can also report an incident to the New York State Department of Health. The Director of Risk Management also stated an injury of unknown origin or alleged abuse incident should be reported immediately once the facility has found out about it. The Director of Risk Management further stated Resident #1 returned to the facility on the evening of 09/15/2025, and the incident was reported the next on 09/16/2025 at 02:54 PM. The Director of Risk Management stated they reported the incident when they got the confirmation of injury. 10 NYCRR 415.4(b)(2)</p>		