| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335063 | A. Building<br>B. Wing | 04/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Coler Rehabilitation and Nursing Care Center | 900 Main Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure ensure that a resident was free of any physical restraint not required to treat the resident's medical symptom and that there was documented ongoing reevaluation of the need for the restraint. This was evident in one (1) (Resident #216) of two (2) residents reviewed for physical restraints out of 40 total sampled residents. Specifically, Resident #216 was observed lying in bed between two (2) large body-sized pillows which were positioned between the mattress and bed sheet that could not be removed without removing the bed sheet. There was no documented evidence of a physician's order to use the two (2) large body-sized pillows under the bedsheet or ongoing reevaluations of the use of the pillows. The findings include: The facility policy titled, Side Rails/Bed Rails, dated 07/23/2025, documented that physical restraints include any manual method, physical, or mechanical device, material, or equipment that is attached to or positioned adjacent to a resident's body, which the individual cannot easily remove, and that restricts their freedom of movement or access to their own body. The facility policy titled, Side Rails/Bed Rails, did not discuss the procedure for the use of potential restraint devices other than siderails/bedrails. ^ No other policy addressing physical restraints was provided by the facility. Resident #216 had diagnoses including Alzheimer's Disease and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #216 had severe cognitive impairments, displayed daily physical behavioral symptoms towards others and other daily behavioral symptoms not directed towards others. It also documented that Resident #216 did not have upper or lower extremity impairments but required dependent-level assistance for rolling left and right in bed and for transfers from the bed to chair. The assessment also documented that Resident #216 did not use any restraints while in bed. On 04/01/2026 at 09:32 AM, Resident #216 was observed awake in bed with upper half side rails raised on both sides of the bed. Two (2) large body-sized pillows were observed with one (1) on each side of Resident #216 secured under the bed sheet, between the bed sheet and the mattress; the pillows could not be removed by the resident while in bed. The pillows extended in length from Resident #216's head to their ankles. The Rehabilitation Referral Form dated 02/20/2025 documented that Resident #216 was referred to Physical Therapy because the resident's family requested the use of long pillows related to non-purposeful leg movements while in bed. The form listed the need for referral to be for consideration of a positioning device such as a long pillow or body aligner while the resident was in bed. The recommendation listed a body aligner for additional positioning and pressure relief when in bed. The form addressed one (1) pillow provided by the family to be used for comfort as safe. The referral form did not document that the placement of the pillow to be secured under the bed sheet was addressed and evaluated for appropriateness or safety. The Comprehensive Care Plan related to Behavior initiated 06/08/2023 documented that Resident #216 had a behavior problem/dementia-related behavior symptoms related to cognitive impairment with mood symptoms, including banging their legs on their bed rails seeking attention, and banging their feet and arms on the surfaces. The Comprehensive Care Plan did not reference the use of the two (2) large body-sized pillows secured under the bed sheet as an intervention. The Comprehensive Care<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Plan did not address the resident moving to the side of the bed as a behavior. The Comprehensive Care Plan related to Activities of Daily Living, initiated on 06/08/2023, documented that Resident #216 had a self-care performance deficit and required total assistance in activities of daily living. The specific placement of two (2) large body-sized pillows to be secured in a manner not removable by the resident was not addressed in the care plan. The care plan did not reference the long pillows in any intervention/task prior to 04/01/2026. The care plan also documented the intervention last revised on 01/01/2026 for the resident to roll left and right with substantial/maximal assistance with one-person physical assist with the use of 2 upper side rails for bed mobility and positioning. The intervention did not address the bilateral pillows positioned between the resident and the upper side rails in reference to bed mobility and positioning. The Nursing Progress Note dated 06/30/2025 documented that Resident #216 experienced behaviors of yelling, screaming, and banging their hands and legs on their side rails at night. The Nursing Progress Note dated 12/12/2025 documented that Resident #216 was noted banging their right leg against the side rail and screaming throughout the night. On 04/01/2026 at 09:47 AM, Registered Nurse #3 observed Resident #216 in bed with the surveyor while Resident #216 was awake in bed with the two (2) large body-sized pillows on each side of the resident. Registered Nurse #3 stated that Resident #216 had a history of attempting to get out of bed at night and that Resident #216's family had requested full bilateral side rails be used to prevent the resident from getting out of bed at night. Registered Nurse #3 stated that Resident #216 then began to bang on the side rails, so the facility began to use the pillows to protect the resident from being injured while banging on the side rails. Registered Nurse #3 stated that they believed the order for the pillows had been placed on 06/09/2023 under an order for a wedge cushion, and stated that the order should have specified where to place the wedge cushion, that two (2) cushions were in use instead of one (1), and what the indication of use was for the wedge cushions. On 04/01/2026 at 10:01 AM, Registered Nurse #4, who is the Head Nurse on Resident #216's unit, was interviewed after observing Resident #216 awake in bed with the two (2) large body-sized pillows on each side of the resident with the surveyor. Registered Nurse #4 stated that the two (2) large body-sized pillows on each side of the resident under the bedsheet was considered to be a potential restraint, and that there should have been a physician's order in Resident #216's medical chart indicating why the pillows were being used, how many pillows were ordered to be used, and where the pillows were to be positioned. Registered Nurse #4 also stated that a comprehensive care plan should have been created to address the use of the pillows by the nurse on duty when the pillows were first utilized. Registered Nurse #4 stated that they had transferred to this unit after Resident #216 began using the bilateral large body-sized pillows but that they should have realized that the accurate order and care plan was not in place and added it at that time. Registered Nurse #4 stated that the rehabilitation department was responsible for completing quarterly assessments on the two (2) large body-sized pillows. On 04/01/2026 at 12:05 PM, the Deputy Director of Nursing was interviewed and stated that Resident #216 had a behavior of moving to the side of the bed, so Resident #216 utilized wedge pillows as positioning devices, which were first ordered on 06/09/2023. The Deputy Director of Nursing stated that the order stated apply wedge cushion while in bed but did not include an indication for use or a location for where staff should apply the wedges, both of which should have been included in the order. The Deputy Director of Nursing stated that there should have been quarterly assessments for the use of the wedge cushions, and that a comprehensive care plan should have been created and updated quarterly by the Nurse Supervisor on the unit. The Deputy Director of Nursing stated that they were not sure why the order specifications, quarterly assessments, and care plan were not completed. On 04/01/2026 at 11:38 AM, the Director of Rehabilitation was interviewed and stated that the rehabilitation department did not issue large body-sized pillows to Resident #216 and that they were not sure if the pillows in use were related to the wedge device order from 2023. The Director of Rehabilitation stated that the Rehabilitation Department manages bed mobility devices, and the Nursing Department is responsible for assessing and managing devices related to resident behaviors.<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/02/2026 at 09:59 AM, Certified Nursing Assistant #1 was interviewed and stated that Resident #216 requires total care with all tasks. Certified Nursing Assistant #1 stated that Resident #216's family had brought the two (2) large body-sized pillows for Resident #216 to use in bed for comfort on an unknown date. Certified Nursing Assistant #1 stated that Resident #216 is unable to remove the pillows while in bed because they are positioned under the bedsheet to ensure they remain in place. Certified Nursing Assistant #1 stated that Resident #216 had previously utilized full bedrails but currently used upper half bedrails and that Resident #216 was able to hold onto the bedrails while turning during incontinence care. On 04/02/2026 at 10:27 AM, Registered Nurse #4 was reinterviewed and stated that on 02/15/2025, Resident #216's family had brought in a pillow for the resident to use for comfort, and that the pillow had been assessed by the Rehabilitation Department as being safe for Resident #216 to use on 02/20/2025. Registered Nurse #4 stated that there had been a lapse in communication between them and the former Head Nurse on the unit, and that was why the facility failed to continue to complete quarterly assessments to ensure that the use of the pillow continued to be safe for the resident to use. Registered Nurse #4 stated that they did not know if the assessment on 02/20/2025 had also assessed the safety of a second pillow being used, or if it assessed the safety of the pillows being used under the bedsheet. On 04/02/2026 at 12:07 PM, the Deputy Director of Nursing was reinterviewed and stated that they reviewed Resident #216's chart again and found that in February 2025, the Rehabilitation Department assessed the use of a body pillow for comfort as being safe for Resident #216 after their family brought a pillow in. The Deputy Director of Nursing stated that they were not sure if the assessment was for the use of one (1) or two (2) large body-sized pillows, and that they were not sure when the use of the second pillow was implemented. The Deputy Director of Nursing stated that the nursing department should have continued to assess the use of the two (2) large body-sized pillows on a quarterly basis because it was a potential restraint, and that a care plan should have been created for the use of the pillows. The Deputy Director of Nursing stated they were not sure why the assessments and care planning did not occur. On 04/06/2026 at 11:22 AM, Medical Doctor #2 was interviewed and stated that Resident #216 had previously utilized bed rails for mobility and positioning but Resident #216's family wanted a more comfortable alternative for the resident, so the family brought in a body-sized pillow for Resident #216 to use in bed. Medical Doctor #2 stated that they were not sure when the second body-sized pillow was added or if Resident #216 had been assessed to ensure that it was safe to use both large body-sized pillows at once while the resident was in bed. Medical Doctor #2 stated that they were not aware that an order was needed for the use of the two (2) large body-sized pillows under the bedsheet while the resident was in bed, and that they were not the covering doctor when the first pillow was implemented in February 2025. On 04/06/2026 at 11:42 AM, the Director of Rehabilitation was interviewed and stated that the Physical Therapy assessment dated [DATE] assessed the safety of the use of one (1) long pillow, not two (2) long pillows. The Director of Rehabilitation stated that they did not know when the second pillow was added and that the nursing department should have sent a referral to the physical therapy department to have Resident #216 reevaluated for the use of the second pillow. The Director of Rehabilitation stated that the assessment completed 02/20/2025 did not document if it was safe for the pillows to be secured underneath the bedsheet. On 04/06/2026 at 11:46 AM, the Physical Therapist Supervisor was interviewed and stated that the Physical Therapy assessment dated [DATE] was related to the use of one (1) pillow that Resident #216's family brought in for comfort. The Physical Therapy Supervisor explained that when a device is considered appropriate, it means that the assessor determined the device would not cause skin issues and would not be a risk for entrapment. The Physical Therapist Supervisor stated that the use of two (2) pillows would require a separate assessment, and that nursing would have had to put in a referral for physical therapy to be made aware of the additional pillow and the need to assess it. The Physical Therapist added that assessment for the risk of entrapment and care planning should be conducted quarterly. On 04/06/2026 at 12:05 PM, the Medical Director was interviewed and stated<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that after the family brought in the second pillow, the nursing department should have placed a referral for the rehabilitation department to assess the safety of the use of both pillows. The Medical Director stated that they did not know why the use of the second pillow had not been assessed, why there was not an order for the use of both pillows, and why there was no ongoing reevaluation or care plan related to the two (2) large body-sized pillows. On 04/06/2026 at 02:47 PM, the Director of Quality Management stated that the facility did not have a policy that addressed physical restraints other than the policy titled Side Rails/Bed Rails dated 07/23/2025. 10 New York Codes, Rules and Regulations 415.4(a)(2-7) |