STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335108	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sea View Hospital Rehabilitation Center and Home	460 Brielle Ave Staten Island, NY 10314

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** Based on observation record review, and interviews during an abbreviated survey (NY00358546), the facility failed to ensure that a resident was treated with dignity included being free from physical or chemical restraints imposed for the purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. This was evident for one (1) out of 5 (five) residents (Resident #1) sampled. Specifically, on 10/26/2024 at approximately 7:10 AM Resident #1 was observed lying in bed with their left ankle tied with a bed sheet to the bed rail. Patient Care Technician #1 admitted to restraining Resident #1. Resident #1 was restrained for the purposes of discipline or convenience. The findings are: The facility's Policy and Procedure titled Prevention of Abuse, Neglect, Exploitation, and Misappropriation of Property and other reportable incidents date of January 16, 2025, documented the facility residents had a right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, neglect, exploitation, mistreatment, involuntary seclusion and any physical or chemical restraint not required to treat resident's medical symptoms. The facility's Policy and Procedure titled Physical Restraints had a revised date of 03/07/2022. The policy documented that the facility recognizes and respects the right of their residents to be free from physical and chemical restraints unless medically indicated and permit under applicable laws, guidelines, and standards. Resident #1 was admitted to the facility with diagnoses including Anxiety Disorder, Psychotic Disorder, and Insomnia. The Minimum Data Set, dated [DATE] documented Resident #1 had moderately impaired cognition. The Minimum Data Set documented Resident #1 had physical and verbal behavior directed at others. (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	The Incident Report dated 10/26/2024 at 7:25 AM documented Patient Care Technician #2 called Registered Nurse #1 to Resident #1's room where Resident #1 was observed lying in bed with a bed sheet loosely around their left ankle. The sheet was removed and there was no redness, discoloration, skin tear, or swelling observed. There was no sign and symptom of trauma noted. The facility investigated and concluded that the incident was verified, however, was without mal-intent and did not lead to physical, emotional, or psychological harm. Patient Care Technician #2 was immediately removed from the unit and was suspended. The Patient Care Technician #2 resigned while they were out on administrative leave on 03/13/2025. The facility immediately conducted restraint check on all cognitively impaired residents to ensure they are not being restrained. A nursing progress note dated 10/26/2024 at 10:26 AM documented Registered Nurse #1 was called to Resident #1's room by Patient Care Technician #2. Resident #1 was observed lying in bed with a sheet loosely around their left ankle. The sheet was removed, there was no redness, discoloration, skin tear, or swelling. There were no signs and symptoms of trauma noted. The physician progress note dated 10/26/2024 at 9:00 AM documented Resident #1 was alert and verbally responsive with baseline confusion. There was no trauma. A complete body assessment was done and there was no evidence of any trauma, skin discolorations, or bruises. The skin was intact, and Resident #1 denied pain. There were no changes in range of motion. During an interview on 03/25/25 at 1:10 AM, Patient care Technician #2 stated they were conducting morning rounds at the start of their shift on 10/26/2024 at approximately 7:10 AM and when they entered Resident #1's room, they observed Resident #1 lying in bed with a bed sheet loosely tied over Resident's left ankle and tied to the bottom bed rail. They immediately notified Registered Nurse #1 who removed the sheet from Resident #1's ankle. During an interview on 03/25/25 at 1:19AM, Registered Nurse #1 stated Patient Care Technician #2 informed them Resident #1's ankle was tied with a bed sheet to the lower bed siderail (can't recall the time). They immediately went to Resident #1's room and observed a loosely tied bed sheet over Resident #1's left ankle and tied to the bottom bed rail. They untied the left ankle and assessed Resident #1. There was no redness, discoloration, complains of pain, and range of motion was within normal limit. Registered Nurse #1 stated no emotional or psychological distress was observed. Registered Nurse #1 stated the unit charge nurse was responsibility for supervising the Patient Care Technicians on the unit. Several attempts were made to contact Patient Care Technician #1 but was unsuccessful. A certified mail was sent to Patient Care Technician #1 on 03/27/2025 with no response. Patient Care Technician #1 provided the facility with a written statement dated 10/26/2024 at 7:30 AM. The statement revealed Patient Care Technician #1 was providing activity of daily living care (did not identify to whom) and heard a nurse yelling that another resident had gotten out of bed. They tied Resident #1's foot to the bed so they could help the nurse put the other resident in bed. During an interview on 03/25/25 at 1:37 PM with Registered Nurse Supervisor #1 (Assistant Director of Nursing), they stated when they arrived on the unit Resident #1 was already out of bed sitting in a shower chair. They performed a full body assessment and there were no visible injuries, no discoloration noted. Registered Nurse Supervisor #1 stated Resident #1 was unable to explain due to impaired cognition. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/25 at 2:21 PM the Risk Manager who conducted the investigation, stated Patient Care Technician #1 was interviewed and stated they were afraid Resident #1 would fall so they secured the Resident's leg before going to assist Registered Nurse #1's called for help. The Risk Manager stated Patient Care Technician #1 acted outside the facility's policy and procedure. The Risk Manager stated they acknowledged that the incident did occur, and that Patient Care Technician #1 acted outside the facility's policy and procedure. It was not Patient Care Technician #1's intention to restraint Resident #1. During an interview on 03/27/25 at 3:24PM the Director of Nursing stated they were informed of the incident by the Assistant Director of Nursing who stated Patient Care Technician #1 admitted they secure the Resident's left ankle to the bed. The Director of Nursing stated the investigation concluded that Patient care Technician #1 restrained Resident. The Director of Nursing stated the nursing supervisors, and they conduct rounds on the units to ensure staff are being monitored and following the re-education. The Director of Nursing stated that abuse did occur because Resident #1 was restraint. However, it was unintentional with resident safety in mind at the time of the incident. The Director of Nursing stated they are monitoring the residents monthly to ensure restraints are not being used. The Director of Nursing stated that Patient Care Technician #1 has not worked in the facility since the day of the incident. During a telephone interview on 03/28/2025 at 10:11 AM the Administrator stated they were not in the facility at the time but received a from the Assistant Director of Nursing informing them of the alleged incident on 10/26/2024. The Administrator stated they met with Patient Care Technician #1, and they admitted to loosely tying Resident #1's ankle to the bed to prevent the Resident from falling. Based on the following corrective actions taken, there were sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to and during the time of this survey. A Plan of Correction is not required for this citation. The facility took immediate corrective actions and was found to be incompliance on 11/04/2024, prior to Surveyors' entrance on 03/25/2025. On 10/26/2024, Policy on restraint and Abuse was reviewed. No revisions were done. The facility took immediate corrective actions. On 10/26/2024 - Patient Care Technician #2 immediately notified Registered Nurse #1 who removed the bed sheet and assessed the Resident. On 10/26/2024 - Nurse Practitioner #1 was informed and assessed the resident. No new orders were obtained. On 10/26/2024 - Patient Care Technician #1 was suspended pending investigation and did not return to position and then resigned on 03/17/2025. On 03/13/2024 - Patient Care Technician #1 resigned. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/2024 - Policy on restraint and abuse was reviewed. Abuse policy was revised dated January 16, 2025. On 10/27/2024 - a facility-wide in-service on restraint and alternatives to restraint was conducted - 100% of staff was in-serviced. 100% (127/127) Patient Care Technician in-serviced. 100% (22/22) Licensed Practical Nurse in-serviced. 100% (72/72) Registered Nurses in-serviced. 100% all staff received in-services on Restraint and Purposeful rounding, One-to One Close Monitoring, Abuse, Neglect, Mistreatment, Misappropriation of Resident Property, and Exploitation. On 11/04/2024 to 03/11/2025 - Audit Tool Restraint Observation reviewed. Monthly audits were performed on 30 Residents who are cognitively impaired, there was no restraints identified. On 11/04/2024 - Quality Assurance and Performance Improvement meeting was held Topic: Resident #1 in bed with a bed sheet on their left ankle and secured to the bed by Patient Care Technician #1. Attendance sheet with names of attendees obtained. 10 NYCRR 415.4(a) (2-7)