STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335296	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sarah Neuman Center for Rehabilitation and Nursing	845 Palmer Avenue Mamaroneck, NY 10543

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 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 conducted during the Abbreviated Survey(NY00375662), the facility did not ensure the development and implementation of comprehensive person-centered care plans to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being for 1(Resident #1) of 3 reviewed for behaviors. Specifically, Resident #1 had a history of behaviors that included resisting Activities of a Daily Living cares from staff, and the facility was unable to provide documented evidence that a Behavior Care Plan was in place prior to 3/25/25. The Findings are: The 10/1/2018 Facility policy titled Comprehensive Care Planning documented that the Interdisciplinary Team(IDT) reviews the Care Plans during the care plan meeting, triggered and other care issues and ensure care plans are in place which address the issues, and reviews and updates care plans at least quarterly and more frequently as warranted by the resident's condition Resident #1 was admitted with diagnoses including but not limited to dementia with behavioral and mood disturbances, difficulty in walking, history of falling, and legal blindness The 12/27/24 Annual Minimum Data Set(MDS-an assessment tool) documented that Resident #1 had severely impaired cognition. The 1/31/25 Behavior Note documented that Resident #1 refused morning care despite encouragement. The 2/13/25 Nursing Progress Note documented that Resident #1 refused care despite multiple attempts. The 2/15/25 Nursing Progress Note documented that Resident #1 refused Activity of Daily Living Care to lower half of their body. The 2/17/25 Nursing Progress Note documented that Resident #1 refused to get out of bed and be helped by the Certified Nurse Aide to be repositioned. Multiple efforts were made by the Certified Nurse Aide and the Nurse, but the resident was verbally abusive. Also, according to the Certified Nurse Aide, the resident refused to get up to eat both breakfast and lunch as well. The 2/18/25 Nursing Progress Note documented that Resident #1 is non-compliant with redirection, observed getting out of bed on their own and walking in the room to look for candy, and refused for to be taken to the television room. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/13/25 Nursing Progress Note documented that Resident #1 is very uncooperative, combative, and attempted to redirect the resident for safety for fall, but Resident did not follow directions and refused to sit down and kept on walking around while staff offered to walk with resident, they remained uncooperative. Upon review of Resident #1's Care Plans, there was no documented evidence that a Behavior/Resistive to Cares Care Plan was initiated prior to 3/25/25. During an interview on 6/3/25 at 2:34 PM, the Director of Nursing stated that Resident #1 has history of behaviors and is resistive and noncompliant with cares from staff, and that when they discovered that Resident #1 did not have a Behavior/Resistive to Cares Care Plan, they instructed the Nurse Manager to initiate one in which was initiated on 3/25/25. The Director of Nursing stated that the Nurse Managers are responsible for initiating Care Plans and that the Nurse Manager is new to the unit and was going through Care Plans and observed that Resident #1 did not have a Behavior/Resisting of Cares Care Plan in place, therefore one was its in. During an interview on 6/3/25 at 3:37 PM, Registered Nurse Unit Manager #1 stated that it is their responsibility to initiate and update the Care Plans, but they are new to the facility just completed orientation, and they have 80 residents and have been reviewing quarterly care plans. Registered Nurse Unit Manager #1 stated that they have been learning the residents and once they identity them as being resistive to cares, they will put initiate a care plan. 10 NYCRR 415.11(c)(1)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review and interviews conducted during an Abbreviated Survey (NY00375662), the facility did not ensure that adequate supervision and effective use of the facility's monitoring program to prevent falls and injuries were provided for 1 (Residents #1) of 3 residents reviewed for accidents. Specifically, on 3/20/2025, Resident #1 who had a history of falls and balance problems and required one-person assistance for toileting was left alone in the bathroom by Certified Nurse Aide #1. Resident #1 fell backwards which caused them to hit their head and sustain an abrasion to the posterior scalp with some bleeding. The Findings are: The 5/5/2015 Facility policy titled Falls Prevention and Management last updated 11/2024 documented that it is the facility policy to assess all Residents for risk of falling, and to implement person centered prevention plans as necessary. Resident #1 was admitted with diagnoses including but not limited to dementia with behavioral and mood disturbances, difficulty in walking, history of falling, and legal blindness. The 12/27/2024 Annual Minimum Data Set (MDS-an assessment tool) documented that Resident #1 had severely impaired cognition and required supervision with toileting and transfers. The 3/20/2025 Accident and Incident Report documented that Resident #1 was observed lying on the floor in a supine position, actively bleeding from their head. The 3/20/2025 Internal Investigation documented that Resident #1 was observed laying supine on the floor in between their bathroom and their room with some bleeding noted to their head. Resident was assessed by a Registered Nurse and a Nurse Practitioner. During the investigation, Certified Nurse Aide #1 reported that Resident #1 refused to be changed by them but instead went in the bathroom and closed the door leaving a slight opening. Certified Nurse Aide #1 who was still able to see Resident #1, reported that Resident #1 placed both legs in the same leg of their underpants causing them to fall backwards which lead to an abrasion of the posterior scalp with a small amount of bleeding. The 7/31/2024 Falls Care Plan documented that Resident #1 has had multiple falls. Interventions included assisting Resident #1 with ambulation and transfers. The 7/27/2024 Activities of a Daily Living (ADL) Care Plan documented that Resident #1 has an Activities of a Daily Living self-care performance deficit related to activity intolerance, dementia, fatigue, and impaired balance. Interventions included but not limited to Resident #1 required touching assistance by one staff for toileting and transfers. There was no documented evidence that a Resistant to Cares Care Plan was initiated prior to 3/25/25 upon review of Resident #1's care plans. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 5/19/2025 at 11:55 am, the Assistant Director of Nursing #1 stated that Resident #1 went to the bathroom by themselves, and closed the door leaving it slightly a opened, and that Certified Nurse Aide #1 reported to them that they observed Resident #1 placing both of their legs in the same leg of their underpants causing them to lose their balance, and falling backwards. The Physician recommended for the resident to be sent to the hospital, but the family refused. The Assistant Director of Nursing #1 stated that they did an investigation and reported the fall to the Department of Health because Resident #1 had an injury to the back of their head with bleeding. During an interview on 5/19/2025 at 12:05 pm, Certified Nurse Aide #1 stated that at approximately 10 am on 3/20/2025 they went in to Resident #1's room to provide cares and they observed that their briefs were soiled. Certified Nurse Aide #1 stated that Resident #1 initially refused cares and if the resident says no, they meant no. Certified Nurse Aide #1 stated that they were able to encourage Resident #1 to go to the bathroom and when they told them to hold on to the assist bar in the bathroom, Resident #1 yelled at them and told them to get out of bathroom. Certified Nurse Aide #1 stated that they went out of the bathroom but left the bathroom door slightly open to see the resident and observed Resident #1 putting both feet in their underpants, and at the same time trying to pull the sliding door to the bathroom causing them to fall backwards. Certified Nurse Aide #1 stated that Resident #1 required assistant with toileting but was resistant to cares and never wanted anyone to help them and if they say no, it meant no. During an interview on 5/27/2024 at 3:53pm, the Director of Nursing stated that Resident #1 has cognitive impairment and should always have someone with them for Activities of Daily Living including toileting. Resident #1 should never be left alone in the bathroom because they have unsteady gait. The Director of Nursing stated that if they are left in the bathroom alone, there is no guarantee that they will ring the call bell and that is why they should not be left alone. The Director of Nursing stated that the resident is a high risk for falls and that the Certified Nurse Aides know that someone must always be with them when they are in the bathroom and not leave them alone. 10 NYCRR 415.12 (h)(1)