

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Sarah Neuman Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on record review and interviews conducted during abbreviated surveys #2607851 and #2580703 the facility failed to ensure that the resident environment was free of accident hazards and/or that each resident received adequate supervision to prevent accidents for two (2) of three (3) residents (Residents #1 and #2) reviewed for accidents. Specifically, 1) on 09/03/2025 Resident #1 was transferred via Hoyer lift (mechanical device) by Certified Nurse Aide #1 and Private Aide #1, who was not approved to provide clinical or nursing care functions. Subsequently, Resident #1 sustained a hematoma (collection of blood) to the back of their head, and 2) on 08/03/2025 Resident #2 was transferred by Certified Nurse Aide #2 without the use of a Sara lift (mechanical sit-to-stand device) and an additional staff member as care planned. Subsequently, Resident #2 sustained a swollen knee that was red and warm to touch, and Resident #2 had complaints of pain. This resulted in actual harm to Resident #1 and Resident #2 that is not Immediate Jeopardy. The findings include:</p> <p>The undated policy titled, Sitter/ Non-Trained Staff Utilization, documented sitters and other non-trained staff shall not perform any clinical or direct nursing care functions.</p> <p>The undated facility fact sheet for private nurse aide and private duty companion/sitter documented private duty companion/sitters are not certified nurse aides in long-term care.</p> <p>The undated policy titled, Activities of Daily Living Care, documented establish guidelines for providing comprehensive assistance with activities of daily living to residents or patients and aims to ensure that everyone's basic needs are met while promoting dignity independence and comfort.</p> <p>The undated policy titled, Mechanical Lift documented two (2) or more people are necessary to safely transfer a resident with a mechanical lift.</p> <p>1.Resident #1 had diagnoses which included cerebrovascular accident (stroke), non-Alzheimer's dementia (decline in mental ability), and hypertension (high blood pressure).</p> <p>The 10/19/2023 in-service training record for Mechanical Lift Policy, Safety Position, and Lift Patients documented Certified Nurse Aide #1 received training on the proper use of mechanical lifts.</p> <p>(continued on next page)</p>

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 12/21/2023 care plan titled Physical Therapy documented the resident requires total assistance of two (2) staff for transfers via Hoyer lift. The care plan was initiated 12/21/2023 and revised 08/26/2025. The 11/29/2024 Annual Minimum Data Set (a resident assessment tool) documented Resident #1 had severely impaired cognition, functional limitation of bilateral (both) upper and lower extremities, used a wheelchair for locomotion, and received dependent assistance with transfers.</p> <p>The 01/15/2025 care plan titled, Activities of Daily Living Self-Care Performance Deficit, documented the resident was totally dependent for transferring using Hoyer lift with two (2) staff assistance.</p> <p>The current Kardex (certified nurse aide instructions) documented chair/bed to chair transfer dependent via Hoyer lift with two (2) staff assistance.</p> <p>The 03/13/2025 physician order documented totally dependent on two (2) staff assistance for transfer via mechanical lift.</p> <p>The 03/20/2025 in-service training record titled, Prevention and Management of Resident Accident and Incidents, documented Certified Nurse Aide #1 received training on the proper use of mechanical lift/s.</p> <p>The 08/26/2025 care plan titled, Resident is on Anticoagulant Therapy related to Cerebrovascular Accident, documented administer medications as ordered and handle the resident gently during care.</p> <p>The 09/03/2025 at 6:45 PM nursing progress note by Registered Nurse Supervisor #1, documented Resident #1 was being transferred by Certified Nurse Aide #1 from the wheelchair to bed via Hoyer lift, and during the transfer, Resident #1 struck the occipital (back and lower part of head) of their head on the nightstand. The small hematoma measured approximately 0.5cm. The physician and family were notified of the incident. Neuro checks were initiated.</p> <p>The 09/03/2025 Incident Report statement by Registered Nurse Supervisor #1 documented Private Aide #1 assisted Certified Nurse Aide #1 to transfer Resident #1 using a Hoyer lift. The lift belt became loose between Resident #1's thighs, and Resident #1 sustained a 0.5 cm hematoma to the back of their head.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 09/03/2025 Incident Report statement documented by Certified Nurse Aide #1 revealed they transferred Resident #1 from the wheelchair to the bed using the Hoyer lift with assistance from Private Aide #1. They stated one (1) of the safety straps came loose and Resident #1's head met the chest of drawers.</p> <p>The 09/03/2025 care plan summary note documented Resident#1 had a hematoma measuring 0.5 x 0.5 cm to the back of the head. Ice was applied.</p> <p>The 09/11/2025 Termination of Employment notice documented Certified Nurse Aide #1 was terminated effective September 11, 2025.</p> <p>During an interview on 10/23/2025 at 11:22 AM, Private Aide #1 stated they were in Resident #1's room on 09/03/2025 when Certified Nurse Aide #1 transferred Resident #1 via Hoyer lift. They stated Resident #1 hit their head on the side of the dresser when the strap came off the Hoyer lift.</p> <p>During an interview on 10/23/2025 at 1:48 PM, Certified Nurse Aide #1 stated on 09/03/2025, Private Aide #1 assisted them to transfer Resident #1 using a Hoyer lift. They stated one (1) of the Hoyer lift straps came off while lifting Resident #1 out of their wheelchair and Resident #1 started to slide down. They stated Resident #1 bumped their head on the chest of drawers. They stated they did not know private aides were not authorized to aid with mechanical lift transfers.</p> <p>During an interview on 10/23/2025 at 12:25 PM, Assistant Director of Nursing #1 stated Certified Nurse Aide #1 transferred Resident #1 with the assistance of Private Aide #1 who was not a certified nurse aide and was not employed by the facility. They stated Private Aide #1 was not authorized to perform resident transfers or resident care. They stated Certified Nurse Aide #1 should have asked another certified nurse aide, licensed practical nurse or registered nurse for assistance.</p> <p>During an interview on 10/23/2025 at 4:03 PM, Licensed Practical Nurse #12 stated that on 09/03/2025, there were 43 residents on the unit and there were four (4) Certified Nurse Aides on the evening shift, which was the usual number of staff. They stated the facility staff was educated that private aides were not allowed to perform cares as they were companions. Licensed Practical Nurse #12 stated they performed frequent rounding to assure the Certified Nurse Aides were performing care according to the resident plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/2025 at 4:17 PM, Registered Nurse Unit Manager #1 stated their duties included overseeing everything on the unit and stated they are responsible for all staff on the unit. They stated private aides were companions and were not allowed to assist with Hoyer lift transfers. They further stated certified nurse aides were educated that private aides may not assist with transfers. Registered Nurse Unit Manager #1 stated they performed frequent rounding on the unit to assure certified nurse aides were following resident care plans and mechanical lifts were being used properly.</p> <p>During an interview on 10/24/2025 at 1:40 PM, Medical Doctor #1 stated that on 09/03/2025, during a transfer via Hoyer lift, Resident #1 sustained a hematoma to the back of their head. They stated that Resident #1 was on aspirin which could cause concern for bleeding. They stated the incident could have been avoided if two (2) trained staff had performed the transfer. They stated the risk for an accident was lower when trained staff performed transfers. They stated it was expected that staff never allow untrained staff to perform care. They stated neuro-checks were normal and the resident did not have a negative outcome from the head injury.</p> <p>2. Resident #2 had diagnoses which included cellulitis (infection) of the left lower limb (leg) and bilateral primary osteoarthritis (chronic joint disease) of the knee.</p> <p>The 03/05/2025 in-service training record titled Prevention and Management of Resident Accident and Incidents, documented Certified Nurse Aide #2 received training on the proper use of a Sara lift.</p> <p>The 03/11/2025 physician order documented Resident #2 was to be transferred via Sara lift with two (2) staff assistance.</p> <p>The 05/12/2025 care plan titled Physical Therapy, documented Sara lift with two (2) staff assistance to move between surfaces.</p> <p>The 05/13/2025 care plan titled Occupational Therapy, documented transfer out of bed with two (2) staff assistance via Sara lift.</p> <p>The current Kardex documented chair/bed to chair transfer dependent via Sara lift with two (2) staff assistance.</p> <p>The 08/01/2025 Minimum Data Set documented Resident #2 was cognitively intact, had functional limitation to one (1) lower extremity, used a wheelchair, was dependent for chair to bed/bed to chair and tub/shower transfers.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 08/04/2025 Incident Report written by Registered Nurse #13, documented that on 08/03/2025 during the evening shift, Resident #2 was transferred from a wheelchair to their bed with one (1) staff assistance and without the use of the Sara lift. Resident #2 alleged their knee hit the bed rail causing pain. When the injury was reported, Registered Nurse #13 immediately assessed Resident #2 and discovered swelling, redness and warmth on the right knee. Resident #2 complained of slight pain on the right knee. A full body assessment was completed and revealed no additional injuries. An x-ray of the right knee was ordered by Medical Doctor #1, and no additional injury was found.</p> <p>The 08/05/2025 Medical Provider assessment plan note written by Medical Doctor #1 documented right knee pain/swelling. On Tylenol 1gm X three (3) days, and icy hot patch daily. X-Ray report indicates no acute fracture or dislocation. Continue monitoring pain and swelling.</p> <p>During an interview on 10/23/2025 at 4:23 PM, Certified Nurse Aide #2 stated when they returned Resident #2 to bed on 08/03/2025 during the evening shift, they did not see a required lift pad on the Sara lift. Certified Nurse Aide #2 stated they decided to transfer Resident #2 into the bed by themselves without the use of the Sara lift. Certified Nurse Aide #2 stated they helped Resident #2 stand up, pivoted Resident #2 towards the bed, and placed Resident #2 into bed. Certified Nurse Aide #2 stated Resident #2 did not complain of hitting their knee but did request pain medication after being placed into their bed. Certified Nurse Aide #2 stated they knew Resident #2 was a two (2) person assist via the Sara lift. Certified Nurse Aide #2 stated they violated the physician order and care plan when they transferred Resident #2 alone and without the Sara lift. Certified Nurse Aide #2 stated they had received in service training on use of the Sara lift.</p> <p>During an interview on 10/23/2025 at 5:05 PM, Registered Nurse Unit Manager #1 stated they performed frequent rounding to determine if mechanical lifts were being used properly. They stated they expected nursing staff to follow care plans and medical orders when they provided care to residents. They stated regardless of workload, nursing staff knew they should not perform transfers via Sara lift without two (2) staff assistance. They stated extra lift pads for the Sara lift were available in the nursing office. Registered Nurse Unit Manager #1 stated nurses would assist with transfers if needed.</p> <p>During an interview on 10/24/2025 at 1:48 PM, Medical Doctor #1 stated staff were expected to follow medical orders and care plans and provide care. They stated not everything is avoidable, but when care is provided properly, the risk of injury decreases. Medical Doctor #1 stated they were unable to say if Resident #2's injury was related to the staff member performing the transfer without additional staff assistance and the use of the Sara lift since Resident #2 did not report the incident until the next day.</p> <p>During an interview facilitated by interpreter 761032 on 10/27/2025 at 3:27 PM, Resident #2 stated when the certified nurse aide used their own strength to transfer them from their wheelchair to their bed, they hurt their knee on the metal part of the bed base. Resident #2 stated they keep having knee pain, it always hurts, and the pain effects their entire leg.</p> <p>10 NYCRR 415.12(h)(2)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>The Facility did not take actions aimed at performance improvement, including the methods by which the facility will systematically identify, report, track, investigate, analyze, and use data and information to develop activities to prevent adverse events. Specifically, on 12/22/2025 during the onsite post survey, the facility did not convene a QAPI meeting to determine the root cause analysis for the deficient practice cited during the survey exited 10/23/2025. The last QAPI meeting was convened on 10/17/2025. The facility did not complete their Directed Plan of Correction imposed with a Category 1 remedy and failed to implement their Plan of Correction as directed by the State Agency by their deadline. As a result the Plan of Correction was not fully implemented by the credible alleged date of compliance of 12/16/2025. The first survey exited 10/23/25 and the facility did not have a QAPI meeting since 10/17/2025. The QA team did not convene 15 days after they received the statement of deficiencies. There was no Risk Assessment conducted to determine how they were in non-compliance. The Facility did not address that a Direction Plan of Correction was implemented as a category 1 remedy and also did not implement the plan of correction as directed by the State Agency. During an interview on 12/23/2025 at 1:00 PM with the Administrator they stated they have not had a QAPI meeting to address the negative findings of the audits conducted because the Director of Nursing is on vacation. The plan is to discuss this in the next meeting. The Administrator stated that staff that are not in serviced and trained on the mechanical lift are not working with the residents. They review the schedule every day to see who needs to be trained prior to going on the unit. This is tracked by an excel spreadsheet. The plan is to have everyone in-serviced by 12/31/2025.</p>		