

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER Sprain Brook Manor Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 77 Jackson Ave Scarsdale, NY 10583	
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during survey, the facility failed to ensure residents were free from accident hazards for three of five residents (Residents #1, #5 and #12) sampled for accident hazards. Specifically, 1) On 02/07/2026, Resident #5, who was identified as high risk for falls, with a history of falls, had an unwitnessed fall in the dayroom when the day room was not monitored by facility staff. Resident #5 was transferred to the emergency room on [DATE] with a laceration on left side of face, facial fractures, and an acute subarachnoid hemorrhage (medical emergency characterized by bleeding in space between the brain and the tissues that cover it). 2) On 03/29/2026, Certified Nurse Aides #2 and #3 did not properly inspect a transfer sling prior to transferring Resident #1 with a mechanical lift and the transfer sling broke, causing Resident #1 to fall on the floor and sustain swelling and bruising to the left side of their face. 3) On 06/23/2026, Resident #12, who was identified as at risk for bruising, was observed with left eye bruising after laying their head on a table without cushioning. These incidents resulted in actual harm to Resident #1 and #5 that was not Immediate Jeopardy. The findings are: The undated facility policy titled Accident and Supervision Patients, Visitors, Volunteers documented avoidable accidents occurred when the facility failed to identify the need for supervision, analyze hazards and risks, and implement interventions consistent with the resident's needs. The facility policy titled Mechanical Lift dated December 2025 documented, before each use, check the sling for wear, tears and loose stitching. 1) Resident #5 had diagnoses of Alzheimer's dementia (disease characterized by decline in cognitive function, affecting memory and ability to perform daily activities) and metabolic encephalopathy (disruption in normal brain activity due to chemical or metabolic imbalances). The Minimum Data Set 3.0 (a resident assessment tool) dated 12/04/2025 documented Resident #5 was severely cognitively impaired. The Comprehensive Care Plan related to falls, initiated 10/29/2024 and last revised 05/25/2025, documented interventions to prevent Resident #5 from falling included encouraging the resident to tell staff when they felt weak, a referral to therapy, a psychiatry consult, toileting every two to four hours, maintaining a clutter-free environment, placement in a room closer to the nursing station, taking the resident out of bed when they wake, and placing the resident in high visibility areas when awake. The Incident Investigation dated 09/29/2025 documented Resident #5 had a witnessed fall in front of the nursing station at 2:30 PM when they got up from their wheelchair and staff were unable to catch the resident before they fell to the floor. Resident #5 was bleeding from their left temporal lobe and was transferred to the hospital for Cat scan (computed tomography - imaging test that uses special x-ray equipment to make detailed pictures of the inside of your body). The Incident report further documented that staff were to supervise Resident #5 keeping them in close proximity and to intervene promptly. The Fall Risk assessment dated [DATE] documented Resident #5 was at (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 0689 Level of Harm - Actual harm Residents Affected - Few	high risk for falls. The Care Plan related to falls was revised 09/29/2025 and included an intervention to redirect Resident #5 to sit back down in their wheelchair when they attempted to get up unassisted, and responding promptly when Resident #5 attempts to get up unassisted. The Incident Investigation dated 10/03/2025 documented Registered Nurse #3 responded to a thud in the dayroom at 6:30 PM and found Resident #5 on the floor. Resident #5 was placed on one-to-one supervision pending result of bilateral hip and pelvis x-rays. The 10/03/2025 incident investigation included Staff Education and that staff monitoring the dayroom would sit next to Resident #5 for immediate intervention. The care plan related to falls dated 10/29/2024 included a revision added on 10/03/2025 to that Resident #1 be placed on one-to-one supervision, which was then discontinued on 10/06/2025. The care plan intervention dated 10/06/2025 documented staff monitoring of Resident #1 in the dayroom will be closer in proximity to the resident to intervene as soon as the resident attempted to stand. The Incident Investigation dated 11/11/2025 documented Resident #5 fell from their wheelchair in the dayroom at 2:35 PM when Certified Nurse Aide #6 turned their back to attend to another resident. The Fall Risk assessment dated [DATE] documented Resident #5 was at high risk for falls. The Care Plan related to falls created 11/11/2025 documented Resident #5 was at risk for falls due to poor safety awareness and interventions included offering toileting every two to four hours and as needed, and repositioning. The Incident Investigation dated 02/07/2026 documented staff responded to a thud in the dayroom at 8:09 AM and observed Resident #5 lying face down on the floor bleeding from the left side of their face. Resident #5 was transferred to the hospital and did not return to the facility. Registered Nurse #2 was suspended for one day for failure to assign staff to monitor residents in the dayroom. There was no documented evidence that Resident #5 was provided with adequate supervision and monitoring to prevent falls while in the unit dayroom on 02/07/2026. The Hospital Discharge summary dated [DATE] documented Resident #5 was admitted to the hospital on [DATE] after an unwitnessed fall from their wheelchair in the facility. Resident #5 was admitted to the hospital with Brain Injury Guideline 3 (a classification for traumatic brain injury severity of the most serious kind with significant intracranial hemorrhage and presence of skull fractures), subarachnoid hemorrhage in the left temporal lobe and sylvian fissure (blood in the spaces of the brain membranes), left orbital (eye socket) fracture, displaced fractures of the anterior, medial, posterolateral walls of the left maxillary sinus (nasal fracture), left-sided forehead laceration, and moderate cerebral volume loss (reduction of brain tissue). Resident #5 was deemed unsafe to eat anything, was placed on comfort care, and was transferred to hospice. The Death Certificate dated 02/13/2026 documented Resident #5's cause of death was complication of blunt force impact trauma of head and torso with facial bone and pelvic fractures and intracranial hemorrhage due to an unwitnessed low-level fall from wheelchair to the floor. An interview was conducted on 06/29/2026 at 12:32 PM with Registered Nurse #1, who stated they were the regular daytime charge nurse on the 4th floor and was familiar with Resident #5 who was a high risk for falls. Registered Nurse #1 stated Resident #5 was placed on unofficial one-to-one supervision, and the aides were instructed to always sit by Resident #5 when the resident was in the dayroom. Resident #5 would end up on the floor as soon as staff turned their backs. Registered Nurse #1 stated Resident #5 required such close supervision they could not be brought off the unit to any activities. Resident #5 was an early riser and was always placed in the dayroom before breakfast. An interview was conducted with Registered Nurse #2 on 06/29/2026 at 11:55 AM, who stated they were assigned as the charge nurse on Resident #5's unit on 02/07/2026 when the resident fell in the dayroom. Registered Nurse #2 stated they neglected to create the dayroom assignment at the beginning of their shift and there was no certified nurse aide assigned to watch the dayroom when Resident #5 fell. Registered Nurse #2 stated they (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	reviewed all facility incident investigations and was under the impression staff were present and witnessed Resident #5's fall in the dayroom on 02/07/2026. The Medical Director stated Resident #5 was at high risk for falls and should not have been left alone. The Medical Director stated they also reviewed the facility investigation regarding Resident #1 falling from the mechanical lift on 03/29/2026. The Medical Director stated this was a freak occurrence and unavoidable. The Medical Director stated there were times that new machines broke down and the administration was responsible for ensuring equipment was maintained in good working conditions. An interview conducted on 07/03/2026 at 11:24 AM with the Administrator, revealed Resident #5 was at high risk for falls and falling in the dayroom was not a common occurrence. The Administrator stated they did not recall if Resident #5 had more than one fall in the dayroom. The Administrator stated the Director of Nursing was responsible for conducting the investigation into Resident #1's fall from the mechanical lift and looking at the lift sling. The Maintenance Department was responsible for checking the mechanical lift machines and slings daily to ensure there were no defective or worn/torn equipment. 10 NYCRR 415.12(h)(2)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a survey, the facility did not ensure nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents. This was evident for two (Residents #1 and #11) of three residents reviewed for staff competency. Specifically, 1) Certified Nurse Aides #2 and #3 did not properly inspect a transfer sling prior to transferring Resident #1 with a mechanical lift. During the transfer, the sling broke, causing Resident #1 to fall on the floor and sustain swelling and bruising to the left side of their face, and 2) Certified Nurse Aide #10 and Certified Nurse Aide #4 were observed transferring Resident #11 with a mechanical lift on [DATE] . Staff did not check to be sure the color-coded transfer sling was attached appropriately and that the mechanical lift charge indicator had adequate power to transfer the resident. During the observation, the mechanical lift lost power during the transfer and staff had to manually maneuver the resident for a safe transfer back to bed. The findings are: The facility policy titled Mechanical Lift dated 12/2025 documented staff were to attach the sling to the hooks of the lifter with the proper amount of staff present. Before each use, slings were checked for wear, tears, and loose stitching. 1) Resident #1 had diagnoses of surgical amputation and muscle weakness. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #1 was moderately cognitively impaired, had limited range of motion of bilateral upper and lower extremities, and was totally dependent on staff for transfers. The facility investigation initiated [DATE] and completed [DATE] documented Resident #1 fell when the sling (lift pad) strap broke during mechanical lift transfer from wheelchair to bed when Certified Nurse Aides #2 and #3 assisted in the transfer. The facility Report to the New York State Department of Health dated [DATE] documented Resident #1 fell from a mechanical lift while being transferred from their wheelchair to bed by Certified Nurse Aides #2 and #3 on [DATE] at 3:30 PM. The sling for the lift gave way and Resident #1 fell to the floor, sustaining bleeding from their mouth. Resident #1 was transferred to the hospital and returned from the emergency room with no recommendations and no acute fracture. The facility terminated Certified Nurse Aide #3 on [DATE] from a third-party staffing agency and was unable to be contacted for interview. Interviews were conducted on [DATE] at 3:01 PM and [DATE] at 2:43 PM with Certified Nurse Aide #2 who stated they were not assigned to Resident #1 on [DATE] and only assisted Certified Nurse Aide #3 on transferring the resident via mechanical lift from their wheelchair to bed. Certified Nurse Aide #2 stated Certified Nurse Aide #3 was assigned to Resident #1 and had already hooked up the sling to the mechanical lift before Certified Nurse Aide #2 entered the room. Certified Nurse Aide #2 stated they did not recall the state of the hooks or the condition of the sling underneath Resident #1. An interview was conducted on [DATE] at 12:32 PM with Registered Nurse #1 who stated they were getting ready to end their shift on [DATE] when they were alerted by Certified Nurse Aide #3 that Resident #1 had fallen from the mechanical lift during transfer. Registered Nurse #2 stated they found Resident #1 on the floor of their room on the left side of their face bleeding from their mouth. The medical team was contacted and 911 was called to transfer Resident #1 to the hospital. Registered Nurse #1 stated they observed the mechanical lift sling hanging with three of four of the straps attached to the hooks of the lift. Registered Nurse #1 stated they could not recall the condition of the sling. Registered Nurse #1 stated Certified Nurse Aide #3 reported to them at the time that the lift sling broke. 2) Resident #11 had diagnoses of chronic obstructive pulmonary disease and dementia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #11 was (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	severely cognitively impaired, had functional impairment of bilateral upper and lower extremities, and was totally dependent on staff for transfers in and out of bed. The Comprehensive Care Plan related to activity of daily living dated [DATE] documented Resident #11 was totally dependent on staff for transfers in and out of bed. Physician Orders dated [DATE] documented Resident #11 be transferred out of bed via mechanical lift with the assistance of two people. Staff Education dated [DATE] and [DATE] documented nursing staff were educated on mechanical lift use. There was no documented evidence Certified Nurse Aides #4 and #10 received mechanical lift education on [DATE] or [DATE]. An interview was conducted on [DATE] at 3:01 PM with Certified Nurse Aide #10 who stated they worked for the facility for approximately three months and floated to different units on the evening shift. Certified Nurse Aide #10 stated their onboarding process included shadowing other senior aides for one to two weeks and having their performance evaluated by a licensed nurse during tasks. Certified Nurse Aide #10 stated they always checked the mechanical lift slings to ensure they were in good condition and attached correctly. They also check the mechanical lift to make sure the machine was functional prior to each resident transfer. On [DATE] at 3:51 PM, Certified Nurse Aide #10 was observed wheeling Resident #11 towards their room for transfer back to bed. The mechanical lift was in Resident #11's room and Certified Nurse Aide #10 hooked the resident's four sling straps (one on each side of the resident's head and one on each side of the resident's legs) to the mechanical lift hooks while Certified Nurse Aide #4 entered the room to assist. Each lift string strap also had four color-coordinated (red, green, blue, and yellow) loops allowing the mechanical lift hooks to attach closer to or farther away from the sling canvas. As Certified Nurse Aide #4 using the lift remote control to hoist the Resident #11's sling was observed hooked to the lifter unevenly with the loop near the resident's left leg hanging more loosely than the other three loops. Certified Nurse Aide #10 was asked during transfer whether Resident #11 was hooked properly to the mechanical lift and the aide did not reply and continued to lift the resident from their wheelchair. Certified Nurse Aide #4 was positioned behind the lift with the remote control in hand. As Resident #11 was placed into their bed, the lift lost power and would not rise off the resident. Certified Nurse Aides #4 stated the mechanical lift battery was dead and they did not know if there was a way to maneuver the lift manually. Hoyer lift died during transfer. Certified Nurse Aides #11 and #4 both repositioned Resident #11 in bed and slid the lift off the top of the resident. The mechanical lift was rolled out of the room by Certified Nurse Aide #4 and left unplugged in the hallway. An interview was conducted on [DATE] at 4:30 PM with Certified Nurse Aide #4 who stated they usually work the night shift and have not received training or in-service from the facility because the facility provided trainings during the day and did not ensure the night shift were included. Certified Nurse Aide #4 stated the mechanical lift is supposed to be plugged in after each use and they did not check the mechanical lift battery during Resident #11's transfer. Certified Nurse Aide #4 stated the aide assigned to the resident was responsible for hooking the resident's sling to the lift. Certified Nurse Aide #4 stated they did not know what the color-coded loops were for and made sure to only use the loop closest to sling canvas to ensure the resident was hooked as close to the lift as possible. An interview was conducted on [DATE] at 1:44 PM with Certified Nurse Aide #9 who stated the transfer sling loops should be hooked evenly to the mechanical lift to distribute the resident's weight evenly. Certified Nurse Aide #9 stated the mechanical lift should always be plugged in after each use to ensure the battery remained charged. Certified Nurse Aide #9 stated the digital screen on the lift flashed an indicator when the battery was running low. An interview was conducted on [DATE] at 3:32 PM with the Director of Nursing revealed they personally inspected the lift sling involved in Resident #1's fall on [DATE] and discovered the stitching attaching the strap to the sling corner was completely unraveled and the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sprain Brook Manor Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 77 Jackson Ave Scarsdale, NY 10583	
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 observations, interviews, and record review conducted during a survey, the facility did not ensure a resident was free from restraints for one (Residents #12) of 3 residents sampled for restraints. Specifically, Resident #12, an ambulatory resident at risk for falls, was observed with another resident's recliner and a chair positioned to prevent the resident from getting out of bed on 06/28/2026. Resident #12 was observed unable to move freely. The findings are: The facility policy titled Resident Rights dated 2022 documented residents have the right to be free from restraints. Resident #12 had diagnoses of dementia and repeated falls. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #12 was severely cognitively impaired, had trouble sleeping, and displayed no inappropriate behavior. The Comprehensive Care Plan related to disturbed sleeping patterns initiated 05/28/2026 documented Resident #12 verbalized difficulty sleeping and would be provided a quiet and comfortable atmosphere to sleep. The Comprehensive Care Plan related to skin integrity initiated 06/10/2026 documented Resident #12 had fragile skin and tended to sleep on their side on the table as evidenced by ecchymosis to the left forehead, left peri-orbital (around the eye) area, and left chin. Interventions included handling Resident #12 gently while providing care. On 06/28/2026 at 8:27 AM, Resident #12 was observed in bed with their head positioned lower than their legs preventing the resident from sitting up. Resident #12 attempted to sit up and could not do so. A recliner labeled with Resident #7's name (who resided in a private room across the hall) was positioned horizontally up against the right side of Resident #12's bed, blocking the resident from being able to freely move on that side. The left side of Resident #12's bed had a bedside dresser and the back of a large chair up against the upper half of the bed, blocking the resident from freely moving on that side. An interview was conducted on 06/28/2026 at 9:05 AM with Certified Nurse Aide #8 who stated they were assigned to Resident #12 and did not know the reason another resident's recliner was in Resident #12's room up against the right side of the bed. Certified Nurse Aide #8 stated they did their rounds when they came in to work at 7AM this morning and did not notice that Resident #12 had the back of a chair blocking their left side and another resident's recliner blocking their right side. Certified Nurse Aide #8 stated no devices should be used to block the side of any resident's bed to block them or restrain them. The facility did not use restraints. An interview was conducted on 06/28/2026 at 10:18 AM with Registered Nurse #4 who stated they were assigned as the unit charge nurse and made visual rounds on residents this morning. Registered Nurse #4 stated they observed the recliner in Resident #12's room this morning and should have removed it. Registered Nurse #4 stated Resident #12 was at risk for falls and staff may have placed the recliner in front of Resident #12's bed to prevent a fall but, even if inconvenient, resident rooms should remain clutter free. Registered Nurse #4 stated the large sitting chairs are for visitors and should not be placed with their backs against any resident bed. Resident #12 was unable to sit up in the chairs that were at their bedside, and the chairs should not be there. An interview was conducted on 06/29/2026 at 3:32 PM with the Director of Nursing who stated they made visual rounds on the units often and have not identified any concerns with devices and equipment being used inappropriately as restraints by preventing residents from getting out of their bed. The Director of Nursing stated the facility did not use restraints. A telephone interview was conducted on 07/03/2026 at 11:24 AM with the Administrator who stated they were not aware of any staff using devices inappropriately as restraints to prevent residents from getting out of bed. The Administrator stated the facility did not use restraints. 10 NYCRR 415.4(a)(2-7)		