

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/01/2025
NAME OF PROVIDER OR SUPPLIER  Mary Manning Walsh Nursing Home CO Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1339 York Avenue New York, NY 10021	

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 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/01/2025
NAME OF PROVIDER OR SUPPLIER  Mary Manning Walsh Nursing Home CO Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1339 York Avenue New York, NY 10021	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, record review, and interviews conducted during an abbreviated survey (2648284), the facility did not ensure a resident's physician was notified of changes in condition. This was evident for one (1) of four (4) residents (Resident #1) sampled. Specifically, on 10/18/2025 at 9:30 AM, Resident #1, who required supervision with ambulation, spilled hot coffee on their right hand while they were ambulating in the hallway holding onto their rolling walker with their left hand, and holding a cup of hot coffee in their right hand. A physician or nursing supervisor was not immediately notified of the changes in Resident #1's condition. Physician #1 became aware of the burn on 10/20/2025 and assessed Resident #1 to have sustained a third-degree burn to their right hand and thumb. Cold compress and Bacitracin Ointment treatment was applied and burn area was covered with dry gauze. The findings include: A policy titled "Notification of Resident's Change in Condition" dated 04/2025 documented that it is the responsibility of the Licensed Nurse/Designee to assess the resident and contact the attending Physician and report pertinent findings, initiate the action indicated by the Physician and document it in the interdisciplinary progress notes. The Licensed Nurse should also notify the nursing supervisor of resident's change in condition, notes on the 24-hour report, interdisciplinary progress notes and communicate changes to the appropriate staff. A review of the Minimum Data Set (a resident assessment tool) dated 08/01/2025 documented Resident #1's cognition was moderately impaired, and they required setup or clean-up assistance during meals. Resident #1 required supervision with ambulation and was able to walk 150 feet. A review of a nursing note by Registered Nurse #1 dated 10/20/2025 at 12:25 PM, documented at approximately 10:30 AM on 10/18/2025 they were informed by Certified Nursing Assistant #1 that Resident #1 burned their right forearm after accidentally dropping hot coffee on it (right forearm). They immediately instructed Resident #1 to dip their right forearm in a basin of water with some ice for 20 minutes. After the allotted time, Registered Nurse #1 dried the right forearm, wrapped it and administered Tylenol for pain. The incident was documented in the huddle book (a book used to endorse report to the next shift). A review of a nursing note by Registered Nurse Manager #1 dated 10/20/2025 at 1:34 PM documented at 8:30 AM, Resident #1 showed Registered Nurse Manager #1 their right hand which presented with three fluid filled blisters, two large blisters on the right index finger and one small blister on the right thumb. As per resident, on 10/18/2025 at 8:30 AM, they were ambulating in the hallway with a cup of coffee in their hand, they lost their grip on the cup spilling the coffee on their right hand. A review of a medical note by Physician #1 dated 10/20/2025 at 4:51 PM documented they were asked to see Resident #1 for third degree burns to their right hand sustained on 10/18/2025. Resident #1 was observed with a large intact blister to the right medial hand and a small vesicle to their right thumb. A review of the Physician's Orders dated 08/27/2025 documented Tylenol 650 milligrams two (2) tablets to be administered by mouth every six (6) hours daily and as needed for pain. An order for Wound Consult dated 10/24/2025 documented evaluate blisters to right hand sustained 10/18/2025. A Wound Care Treatment Daily Order dated 10/25/2025 documented right hand wound to be cleaned with wound cleanser, pat dry, and to apply bacitracin and cover with dry gauze daily. A review of the Medication Administration Record dated 10/2025 showed Resident #1 received Tylenol 650 milligrams as per physician's order. A review of a Surgical Note (Wound Consultation) dated 10/24/2025 documented three (3) bullae (large fluid-fill blisters greater than 10 millimeter) with clear fluid that has started leaking. Bacitracin and dry gauze dressing recommended. A review of the facility's Investigation Summary dated 10/27/2025 documented on 10/18/2025, Resident #1 was ambulating in the hallway on the unit with a cup of coffee in their hand, lost their grip of the cup spilling some of the contents on their right hand. Resident #1 experienced localized erythema to their right hand followed by the formation of a vesicle. On 10/18/2025, Resident #1 was instructed by Registered Nurse #1 to place their right hand in a basin of ice water for twenty minutes and then the hand was wrapped with kerlix. Tylenol was administered to relieve pain, and incident was documented in the huddle book. Incident report further documented on examination, full range of motion present to all extremities, two blisters observed to their hand. The facility investigated and concluded that there was no reasonable cause to believe that abuse, mistreatment, neglect occurred. During an interview on 11/12/2025 at 12:49 PM, Resident #1 stated they walked from their room to the dining room on 10/18/2025 at 8:30 AM to warm up their coffee because their regular certified nursing assistant was off duty. They stated they held the cup of coffee with their right hand as they propelled their walker with their left hand, they burned themselves. They stated they did not ask the other staff for assistance. They stated they know the staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/01/2025
NAME OF PROVIDER OR SUPPLIER  Mary Manning Walsh Nursing Home CO Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1339 York Avenue New York, NY 10021	

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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/01/2025
NAME OF PROVIDER OR SUPPLIER  Mary Manning Walsh Nursing Home CO Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1339 York Avenue New York, NY 10021	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, and interviews conducted during an abbreviated survey (2648284), the facility failed to ensure that an alleged violation involving abuse, neglect, exploitation or mistreatment are reported immediately but not later than two hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. This was evident for one (1) of four (4) residents (Resident #1) sampled. Specifically, Resident #1 spilled hot coffee on their right hand on 10/18/2025 at 9:30 AM. Registered Nurse #1 who was notified by Certified Nursing Assistant #1 on 10/18/2025 at 9:30 AM, did not notify the administrator or designee within 24-hours. Resident #1 was assessed on 10/20/2025 by Physician #1 who diagnosed Resident #1 with third-degree burns to the right hand and right thumb. The administrator was notified on 10/20/2025 before 9:00 AM and they reported the incident to the New York State Department of Health on 10/20/2025 at 11:04 AM. The findings are: A policy titled 'Abuse Prevention Policy and Procedure' dated 03/20/2025 documented all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involves abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials in accordance with State law through established procedures. Resident #1 was admitted to the facility with diagnoses including Heart Failure, Seizure Disorder, and Mood Disorder. A review of the Minimum Data Set (a resident assessment tool) dated 08/01/2025 documented Resident #1's cognition was moderately impaired, and they required setup or clean-up assistance during meals. Resident #1 also required supervision with ambulation and was able to walk 150 feet. During a telephone interview on 11/12/2025 at 1:55 PM, Registered Nurse #1 stated on 10/18/2025 at approximately 9:30 AM, Certified Nursing Assistant #1 informed them Resident #1 burned their right hand after spilling coffee on their hand. They stated they assessed Resident #1's hand and did not observe any blisters. They stated Resident #1's hand was red but not swollen, so they retrieved a basin of water with ice and instructed Resident #1 to place their hand in the water for 15 minutes, then wrapped the hand with kerlix and administered Tylenol. They stated they are aware they should have reported Resident #1's changes in condition, however, it did not occur to them to report the burn incident to the supervisor or physician. They stated they documented the incident in the huddle book (an endorsement/report book for nurses). They stated they did not give a verbal report to the oncoming shift because the oncoming nurse was late. They stated they worked on 10/19/2025 (on Resident #1's unit) but did not follow up with the burn incident and they did not receive a report from the off-going shift). A Webform Submission from: Nursing Home Facility Incident Report dated 10/20/2025 showed the facility submitted the report to the New York State Department of Health on 10/20/2025 at 11:04 AM. During an interview on 11/12/2025 at 2:12 PM, Registered Nurse Manager #1 stated on 10/20/2025 at 8:30 AM Resident #1 approached them and showed them their hand which had two (2) large intact and raised blisters on the right index finger and a small blister on the right thumb. They stated Resident #1 informed them that they warmed up their coffee in the microwave in the dining room because their regular Certified Nursing Assistant was not working. They stated Resident #1 reported while they were ambulating back to their room with the coffee and walker, they spilled the coffee on their right hand. They stated Registered Nurse #1 should have immediately reported the burn incident to the nursing supervisor and physician. During a telephone interview on 11/18/2025 at 1:10 PM, the Director of Nursing stated they were informed of the burn by the Administrator on 10/20/2025 via chat at 8:53 AM. They stated they were out of the country when the Administrator reported Resident #1 spilled coffee on themselves. They stated the team collaborated and concluded that abuse did not occur. They stated it is hard to say that the incident was avoidable, Resident #1 usually asks staff to warm up their coffee but did not ask staff on that day when Resident #1 decided to heat up the coffee themselves. They stated the coffee that Resident #1 receives and asks staff to warm up is brought to them with their breakfast tray. They are not sure on that day if the coffee was from the breakfast tray or if it was Resident #1's personal coffee. They stated there were no care plans to reflect resident's preference for warming up coffee. They stated the incident</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/01/2025
NAME OF PROVIDER OR SUPPLIER  Mary Manning Walsh Nursing Home CO Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1339 York Avenue New York, NY 10021	

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 - Minimal harm or potential for 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>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/01/2025
NAME OF PROVIDER OR SUPPLIER  Mary Manning Walsh Nursing Home CO Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  1339 York Avenue New York, NY 10021	
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, and interviews conducted during an abbreviated survey (2648284), the facility failed to provide an environment that is free from accident hazards and to ensure that a resident received adequate supervision to prevent accidents. This was evident for one (1) of four (4) residents (Resident #1) sampled. Specifically, on 10/18/2025 at 9:30 AM, Resident #1, who required supervision with ambulation, spilled hot coffee on their right hand while they were ambulating in the hallway holding onto their rolling walker with their left hand, and holding a cup of hot coffee in their right hand Resident #1 was assessed on 10/20/2025 by Physician #1 and was diagnosed with a third-degree burn to their right hand and thumb. Cold compress and Bacitracin Ointment treatment was applied and burn area was covered with dry gauze. The findings include:A policy titled 'Microwave Use-Reheating Foods or Liquids in the Microwave' dated 02/2023 documented it is the facility's policy to provide food and hot liquids at comfortable and safe temperatures, ensure that resident's food and/or liquids are reheated safely and ensure microwaves are accessible for use by staff only. The policy further documents residents and visitors will not utilize the microwave but will request from staff to reheat foods and liquids to ensure safety.A policy titled 'Accidents and Supervision' dated 08/2013 documented it is the facility's policy that the resident's environment remains free of accident hazards and that each resident receives adequate supervision and assistive devices to prevent accidents.Resident #1 was admitted to the facility with diagnoses including Heart Failure, Seizure Disorder, and Mood Disorder.A review of the Minimum Data Set (a resident assessment tool) dated 08/01/2025 documented Resident #1's cognition was moderately impaired, and they required setup or clean-up assistance during meals. Resident #1 also required supervision with ambulation and was able to walk 150 feet.A review of Resident #1's care plans revealed no documented instructions for staff to provide supervision during ambulation. A review of the Certified Nursing Assistant Daily Documentation dated 10/2025 revealed no documented instructions for staff to provide supervision during ambulation. A review of the facility's Investigation Summary dated 10/27/2025 documented on 10/18/2025 Resident #1 was ambulating in the hallway on the unit with a cup of coffee in their hand, lost their grip of the cup spilling some of the contents on their right hand. Resident #1 experienced localized erythema to their right hand followed by the formation of a vesicle (small fluid-fill blister). On 10/18/2025, Resident #1 was instructed by Registered Nurse #1 to place their right hand in a basin of ice water for twenty minutes and then the hand was wrapped with kerlix. Tylenol was administered to relieve pain, and incident was documented in the huddle book (an endorsement/report book for nurses). Incident report further documented on examination, full range of motion present to all extremities, two blisters observed to their hand. The facility investigated and concluded that there was no reasonable cause to believe that abuse, mistreatment, or neglect occurred. A review of a nursing note by Registered Nurse #1 dated 10/20/2025 at 12:25 PM documented at approximately 10:30 AM on 10/18/2025 they were informed by Certified Nursing Assistant #1 that Resident #1 burned their right forearm after accidentally dropping hot coffee over it. They immediately instructed Resident #1 to dip their right forearm in a basin of water with some ice for 20 minutes. After the allotted time, Registered Nurse #1 dried the right forearm, wrapped it and administered Tylenol for pain. The incident was documented in the huddle book (an endorsement/report book used by nurses). A review of a nursing note by Registered Nurse Manager #1 dated 10/20/2025 at 1:34 PM documented at 8:30 AM, Resident #1 showed Registered Nurse Manager #1 their right hand which presented with three fluid filled blisters, two large blisters on the right index finger and one small blister on the right thumb. As per resident, on 10/18/2025 at 8:30 AM, they were ambulating in the hallway with a cup of coffee in their hand and lost grip on the cup spilling the content on their right hand. Physician #1 notified and examined Resident #1 with no new orders.A review of a medical note by Physician #1 dated 10/20/2025 at 4:51 PM documented Physician #1 was asked to see Resident #1 for third degree burns to their right hand sustained on 10/18/2025 while carrying a cup of coffee that they reheated in a microwave without asking for assistance. Resident #1 observed with large intact blister to the right medial hand and a small vesicle to their right thumb. Resident #1 was treated with cold compress and Tylenol for pain.A review of the Physician's Orders dated 10/24/2025 documented Wound Care Consult. Evaluate blisters to right hand sustained 10/18/2025. A Wound Care Treatment Daily Order dated 10/25/2025 documented right hand wound to be cleaned with wound cleanser, pat dry, apply bacitracin and cover with dry gauze daily. A review of the Surgical Note (Wound Consultation) dated 10/24/2025 documented wound description -three bullae (large blister on the skin larger than 10</p>		