

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335744	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Grand Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 White Plains Road Bronx, NY 10473	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864</p> <p>Based on observations, staff interviews, and record review conducted during the Complaint Survey (NY00339166, NY00332772), the facility did not ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan and the residents' choices. This was evident for 2 of 3 residents reviewed for medication administration. Specifically, 1.) On 04/02/2024, Resident #6, who had a diagnosis of Diabetes Mellitus, had not been given the prescribed Lantus Insulin (a long-acting insulin used in adults with type 2 diabetes) at 9:00 PM. 2.) On 10/24/2023, Resident #4 was admitted to the facility with hospital discharge orders for an antibiotic intravenous infusion for bacteremia (a medical condition characterized by bacteria in the bloodstream). A review of medical record revealed the antibiotic had not been ordered or administered to Resident #4.</p> <p>The findings are:</p> <p>1.) Resident #6 was admitted to the facility with diagnoses that include Diabetes Mellitus with Diabetic Neuropathy (a type of nerve damage that can occur if you have diabetes).</p> <p>The Minimum Data Set assessment dated [DATE] documented Resident #6 had intact cognition and required set-up for eating, moderate assistance for bed mobility, and dependent for transfers and toilet use.</p> <p>The Physician's Order dated 03/27/2024 documented Lantus U-100 Insulin 100 unit/milliliter, subcutaneous solution: inject 30 units by subcutaneous route once daily at bedtime. Schedule: Every Day at 9:00 PM.</p> <p>The Medication Administration Record for April 2024 documented Lantus was not administered on 04/02/2024 because Resident #6 was asleep.</p> <p>A review of the progress notes from 04/01/2024 to 04/10/2024 did not reveal documented evidence the physician was notified of Resident #6's missed Lantus dose.</p> <p>During an interview on 05/16/2024 at 11:00 AM, Resident #6 stated the nurse had not administered their insulin because they were asleep. They stated the nurse no longer works in the facility, and they had been getting their insulin as ordered after that incident.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/16/2024 at 11:30 AM, Registered Nurse #1, who was the Registered Nurse Supervisor, stated they do not recall receiving a complaint from Resident #6 about not getting their insulin. Registered Nurse #1 stated the physician must be notified when a resident refused or missed a medication.</p> <p>During an interview on 05/16/2024 at 4:20 PM, the Director of Nursing stated they were not aware Resident #6 had a concern with the nurse and that they missed their insulin. They stated the nurse does not work at the facility currently. The Director of Nursing stated the nurse should have written in the progress note that the resident was not administered their insulin, and the physician should have been notified.</p> <p>2.) Resident #4 was admitted to the facility with diagnoses of Diabetes Mellitus with Diabetic Retinopathy and Other Osteomyelitis of Ankle and Foot.</p> <p>The Minimum Data Set assessment dated [DATE] documented Resident #4 had moderately impaired cognition. The resident had orthotics (an artificial support or brace for the limbs or spine) / prosthetics (an artificial device that replaces a missing body part). Resident #4 required supervision to partial to moderate assistance with activities of daily living.</p> <p>The Hospital Discharge summary dated 10/24/2023 documented Resident #4 was admitted to the hospital after falling off a bike followed by falling down the subway stairs, resulting in Fracture of the Right Talus, Right Medial Malleolus, and Right Epicondyle. The resident had surgery, and the infectious disease team was consulted for Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia. The resident was started on a 4-week course of antibiotics from 10/09/2023 to 11/06/2023. The resident will continue to receive intravenous antibiotics via a peripherally inserted central catheter (PICC, a long, thin tube inserted through a vein in the arm and passed through to the larger veins near the heart) at a skilled nursing facility. A copy of the prescription for the administration of the antibiotic was included with an end date of 11/06/2023.</p> <p>A nurse's progress note dated 10/24/2023 at 10:03 PM documented that Resident #4 was admitted to the facility, and the physician was made aware.</p> <p>The Nurse Practitioner notes dated 10/25/2024 at 8:51 AM documented Resident #4 was a new admit. Resident #4 had fallen off a bike, followed by falling down the subway stairs, resulting in Fracture of the Right Talus, Right Medial Malleolus, and Right Epicondyle, and was treated in the hospital for injuries. The note documented that the medication was reviewed and reconciled.</p> <p>The Nurse Practitioner notes dated 10/26/2023 and 10/27/2023 documented Resident #4 was seen for new admission. The notes documented that the medication was reviewed and reconciled.</p> <p>The physician progress note dated 11/02/2023 at 2:59 AM documented the date of service was 10/31/2023. Resident #4 was seen for evaluation and management of hypoglycemia, other comorbidities, and screening for acute issues. The note documented that the medication was reviewed and reconciled.</p> <p>A late entry physician admission note dated 11/10/2023 at 3:30 AM documented the service date as 10/24/2023; the reason for service was subacute rehabilitation admission, medical evaluation history and physical. The note documented Resident #4 was seen and examined at the bedside with no acute concerns. All medications were reviewed and reconciled, and discharge papers were reviewed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The physician's orders from 10/24/2023 through 11/10/2023 did not include the order for an intravenous infusion of the antibiotic.</p> <p>The Medication and Treatment Administration Record from 10/24/2023 through 11/10/2023 had no documented evidence that the antibiotic was administered to Resident #4.</p> <p>A review of the physician and nurses' progress notes from 10/24/2023 through 11/10/2023 had no documented reason for not ordering the antibiotic.</p> <p>The Nurse Practitioner note dated 11/10/2023 documented that Resident #4 had tripped and landed on the right foot. The resident was transferred to the hospital.</p> <p>On 05/16/2024 at 12:15 PM, Registered Nurse #2, who was the Registered Nurse Supervisor, was interviewed and stated they work as the evening shift supervisor at times and would do resident admission. Registered Nurse #2 stated that for new admissions, they would review the physician orders and reconcile them with the list of medications in the hospital discharge summary. They notify the attending physician of the orders, and the discharge summaries are reviewed by the attending physician.</p> <p>On 05/16/2024 at 4:30 PM, the Director of Nursing was interviewed and stated that when a resident is admitted to the facility, the nurse calls the attending physician and reads back the discharge medication orders from the hospital. The Director of Nursing stated the attending physician reviews the medication list from the hospital and reconciles the medications. The Director of Nursing stated Resident #4 had been readmitted to the facility several times, and their medications were always ordered.</p> <p>On 06/11/2024, the Medical Director was interviewed and stated that Resident #4 was seen by the Infectious Disease consultant in November, who discontinued the antibiotic and started the Resident on other medications.</p> <p>10 NYCRR 415.12</p>		