STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335744	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Manor Nursing & Rehabilitation Center	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)
F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45344 Based on observations, record review, and interviews conducted during the Abbreviated Survey and Partial Extended Survey (Complaint NY00362627, NY00363035, NY00363415, NY00358811) beginning [DATE], it was determined that this Special Focus Facility failed to maintain safe and comfortable temperature levels. This was evident on five of five resident floors, where 59 out of 59 rooms sampled had temperatures below the Federal and State requirements in accordance with 42 CFR Part 483 and 10 NYCRR: 415.29. Specifically, four complaints were submitted to the State Agency regarding loss of heat in the facility from [DATE] through [DATE], naming six residents affected. An additional six residents filed grievances at the facility on the loss of heat in their rooms from [DATE] through [DATE]. The facility did not have documented evidence they had identified resident room temperatures were at safe and comfortable ranges. This resulted in no actual harm with likelihood for more than minimal harm to all residents in the facility, which was Immediate Jeopardy and Substandard Quality of Care. The findings are: Observations during the initial tour of the facility on [DATE], from 9:00 AM to 9:00 PM included temperatures in resident rooms, corridors, and stairwells below State and Federal required ranges. Temperatures were observed between (,d+[DATE] degrees Fahrenheit). East, North, and South Stairwells were measured at 40 degrees Fahrenheit. The resident rooms located closest to the stairwells had the lowest temperature readings, as low as 53 degrees Fahrenheit. On [DATE], from 11:00 AM to 12:00 PM, a review of the Maintenance Logbooks located at the Nurse's Stations, on 5 of 5 resident floors, had entries stating that the heating was not working. These entries were made from [DATE] through [DATE] and identified 23 resident rooms that were very cold. On [DATE] at 1:30 PM, the Administrator was interviewed and stated they were not aware there was a loss of heat in the building or that resident rooms were below regulatory ranges. They were not aware that temperatures in some rooms had dropped below 60 degrees Fahrenheit. The Administrator stated the Packaged Terminal Air Conditioner (PTAC) units (self-contained heating and air conditioning system), were not necessary because the boiler provides heat. The Administrator further stated they were not aware the boiler was also not providing heat. The Administrator stated they were in the facility on Sunday, [DATE], just to ensure everything in the building was going well. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the Grievance Book revealed that from [DATE] to [DATE], six residents complained that their rooms have been cold. In an interview on [DATE] at 10:45 AM, the Director of Social Services stated that these grievances had been discussed at two Morning Meetings and at a Resident Council Meeting. A review of the facility's policy on Heating/Cooling, revised on ,d+[DATE] and ,d+[DATE], reveals that it is the facility policy to maintain indoor temperatures within the range of ,d+[DATE] degrees Fahrenheit. The policy also states that the Administrator is responsible for maintaining service contracts for routine and emergency maintenance of heating and cooling systems. A review of the Daily Room Temperature Log Readings for [DATE] to [DATE], revealed that hallway and resident room temperatures on resident floors ranged from 67- 70 degrees Fahrenheit, one resident room was listed at 71 degrees Fahrenheit. The resident room number were not indicated on the log, nor which corridor was measured. The temperature logs listed one temperature reading, once per day. Maintenance Staff #1 stated that temperatures were taken at a random location on each floor. Review of an annual service contract dated [DATE], revealed the service contract expired on [DATE]. A review of the annual service contract with Vendor #2 to maintain the boiler system, dated [DATE], revealed there was no service contract in place from February 2024 through [DATE] for preventive maintenance. Review of Boiler Vendor #1, quote no. 136, dated [DATE], revealed a proposal to remove the boiler objections of a previous report on 14 boilers for a total of $48,776. The facility failed to address the recommendations. Review of Boiler Vendor #1, quote no. 139, dated [DATE], revealed a proposal to provide quarterly services for 12 months. The facility failed to address the recommendations. Review of Vendor #1 Invoice no. 2024800 for a service visit on [DATE], revealed the Director of Maintenance had requested an assessment of the boilers that provide heating and hot water, in preparation for winter. Review of Vendor #1 Invoice no. 20241186 for a service visit on [DATE], revealed the facility had reported insufficient heat. The vendor identified 5 of the 13 boilers in working order. Review of Vendor #1 Invoice no. 20241204, for a service call on [DATE], revealed boiler #6 had to be turned off which left 5 of 13 boilers functioning again. Review of Vendor #1 invoice no. 20241225 for service calls from [DATE] through [DATE], revealed there was insufficient heat in the building. On [DATE] the vendor billed for a mechanic and an assistant for 4 hours during the day to service PTAC units on the 6th Floor and noted there was an insufficient amount of hot water due to some of the boilers not working. An additional service call was made on [DATE] when the facility placed a night call for lack of heat throughout the building. A Saturday call to the vendor was made on [DATE] when the facility again reported a lack of heat throughout the building. The invoice states boilers need to be serviced as soon as possible, as lack of heat is attributed to an insufficient number of boilers working. A service call was made on [DATE] to service PTAC units on the 6th Floor. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 1:15 PM, Vendor #1, stated they serviced the boilers at the facility in [DATE], for an issue of no hot water. The vendor stated the boilers had several problems that stemmed from a lack of maintenance and were operating at about 40%. This contributed to the hot water not getting hot enough to provide hot water or heating for the building. The vendor stated several proposals were sent to the Administrator and the Director of Maintenance via email. The Vendor further stated they had serviced the boilers at the facility in previous years but had stopped because of unpaid bills. For them to return in [DATE], they were given a check for a past due balance. During an interview on [DATE], at 12:40 PM, the Administrator stated their emails are reviewed at least once per day. The Administrator denied receiving any invoices, proposals, or recommendations from any vendors. During an interview on [DATE], at approximately 12:00 PM, Activities Staff #1 and #2, stated they had been called into work on Sunday, [DATE], to distribute hot drinks because of the heating issue. Record review of Nursing In-services, revealed cold weather/cold temperature in-servicing started on [DATE]. Record review of the Grievance log, revealed that from [DATE] to [DATE], six residents complained it was too cold in their rooms. During an interview with the Medical Director on [DATE] at approximately 4:00 PM, the Medical Director stated they were not aware of any heat-related issues in the building. The Medical Director stated if the room temperatures fell below 50 degrees Fahrenheit and remained there for an extended period then residents may develop hypothermia. It is all based on how long the residents were exposed to cold temperatures. Immediate Jeopardy was identified, and the Administrator was notified on [DATE] at 7:25 PM. An acceptable immediate corrective action plan from the facility was received on [DATE] at 11:32 PM Immediate Jeopardy was removed prior to survey exit on [DATE] based on the following corrective actions taken by the facility: 1. Packaged Terminal Air Conditioner units were deployed to all affected areas. Residents were relocated to warmer areas of the facility and twice daily temperature checks of all residents' rooms were conducted by the facility. A review of the temperature logs from [DATE] to [DATE] revealed temperatures within acceptable ranges. 2. Extra blankets and clothing were distributed to the residents by Housekeeping and Activities staff, hot beverages were provided, and residents had the option of staying in the warmer common areas. 3. The Administrator provided a vendor contract to provide annual maintenance to boilers, and for the maintenance of Packaged Terminal Air Conditioner units. 4. The facility completed staff training on identifying and addressing temperature related issues, procedures for reporting issues, deploying emergency measures, and ensuring resident comfort. 100% of staff received the in-service. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	5. A Quality Assurance meeting was held on [DATE] to discuss the findings of the Immediate Jeopardy. Wall thermometers have been installed in residents' rooms and staff were given in-service education on reading the temperature. 6. The Emergency Preparedness plan for Loss of Heat was revised to include immediate deployment of portable units and proactive monitoring and escalation processes for heating issues. 10 NYCRR: 415.29

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 45344 Based on observation, record review, and interviews conducted during the Abbreviated Survey and Partial Extended Survey (Complaint NY00362627, NY00363035, NY00363415, and NY00358811), the facility failed to ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the Administrator failed to provide effective leadership and oversight to ensure that comfortable and safe temperature levels were maintained in residents' rooms and common areas. In addition, the Administrator failed to have an effective system in place to ensure the boiler room equipment was maintained in safe operating condition. This resulted in no actual harm with the likelihood of more than minimal harm to all residents in the facility, which was Immediate Jeopardy. The findings are: 1. Cross refer to F584. Six resident grievances were filed between 12/02/2024 and 12/06/2024 concerning the lack of heat in their rooms. During an observation on 12/06/2024 from approximately 9:30 AM to 11:30 AM and from 8:00 PM to 9:00 PM, temperature readings in corridors, stairwells, and 59 out of 59 sampled rooms were below the State and Federal required ranges. The Administrator denied being aware that there was loss of heat in the building. 2. Cross refer to F908. There was no documented evidence the boiler room equipment and the Packaged Terminal Air Conditioner units were routinely maintained. During an interview on 12/06/2024 at 1:15 PM, the Director of Maintenance was interviewed and stated the Packaged Terminal Air Conditioner units were incorrectly connected and were not blowing hot air. During a subsequent interview on 12/26/2024 at 1:00 PM, the Director of Maintenance stated in the 6 months they were employed at the facility, they attempted to get the boilers serviced. They stated they called the vendor to schedule the services, but they would not come in because of overdue unpaid balances. The Director of Maintenance stated they referred those calls to the Administrator. The Director of Maintenance stated they were not allowed to order materials or services without prior approval from the Administrator. During an interview on 12/06/2024 at 1:30 PM, the Administrator stated they were not aware there was loss of heat in the building. The Administrator stated Packaged Terminal Air Conditioner units were not needed to provide heat in residents' rooms because the facility has boilers. The Administrator stated they were not aware the boilers were also not working. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 12/13/2024 at 1:15 PM, Vendor #1, stated they serviced the boilers at the facility in June 2024, for an issue of no hot water. The vendor stated the boilers had several problems that stemmed from a lack of maintenance and were operating at about 40%. This contributed to the hot water not getting hot enough to provide hot water or heating for the building. The vendor stated several proposals were sent to the Administrator and the Director of Maintenance via email. The Vendor further stated they had serviced the boilers at the facility in previous years but had stopped because of unpaid bills. They stated that they only returned in June 2024, because the facility submitted a check for their past-due balance. On 12/26/2024 at 1:00 PM, the former Director of Maintenance stated that he had received invoices and proposals from Boiler Vendor #1 via email and that the Administrator was on the same emails. During an interview on 12/17/2024, at 12:40 PM, the Administrator stated their emails are reviewed at least once per day. The Administrator denied receiving any invoices, proposals, or recommendations from any vendors. Immediate Jeopardy was identified, and the Administrator was notified on 12/12/2024 at 7:25 PM. An acceptable immediate corrective action plan from the facility was received on 12/12/2024 at 11:32 PM. Immediate Jeopardy was removed prior to survey exit on 12/19/2024 based on the following corrective actions taken by the facility: 1. The Administrator is conducting end-of-day and weekly meetings with department heads to review any issues. 2. 100% of staff have been in-serviced (except those on vacation), a policy was created on how agency staff will also be in-serviced. 3. Morning meetings attended by all department heads are being conducted. 4. Resident council meeting was rescheduled to Friday 12/20/2024. 5. The Administrator provided documentation of regular rounds. 6. Observation of a binder created of Vendor Documents and placed at the Security Desk by the elevators. 7. Emergency Preparedness plan for loss of heating was revised, and discussed at the QAPI meeting, the Administrator is the Acting Director of Maintenance 10 NYCRR 415.26

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45344 Based on observations, interviews, and record review conducted during the Abbreviated Survey and Partial Extended Survey (Complaint NY00362627, NY00363035, NY00363415, and NY00358811), the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition. This was evident in 5 of 5 resident units Specifically, the facility failed to routinely maintain their boiler equipment. This resulted in the facility's heating system malfunctioning, causing temperatures in residents' rooms and common areas to fall below the required range. This resulted in no actual harm with likelihood for more than minimal harm that is Immediate Jeopardy and substandard quality of care to resident health and safety, in accordance with 42 CFR Part 483 and 10 NYCRR: 415.29 The findings are: A review of the facility's boiler service contracts revealed the annual service contract to maintain the boiler system expired on [DATE], the facility currently had no service contract in place. A service quote dated [DATE] for a total of $48,776 documented the vendor proposed to remove the objections for the 14 boilers identified in a previous inspection by another vendor. The facility did not act on this recommendation. On [DATE], the vendor sent a proposal to provide quarterly annual maintenance services on the boilers, which the facility did not act on. Review of Boiler Vendor #1, quote no. 136, dated [DATE], revealed a proposal to remove the boiler objections identified on a previous inspection on 14 boilers for a total of $48,776. The facility failed to address the recommendations. Review of Boiler Vendor #1, quote no. 139, dated [DATE], revealed a proposal to provide quarterly annual services. The facility failed to address the recommendations. Review of Vendor #1 Invoice no. 2024800 for a service visit on [DATE], revealed the Director of Maintenance had requested an assessment of the boilers that provide heating and hot water, in preparation for winter. Review of Vendor #1 Invoice no. 20241186 for a service visit on [DATE], revealed the facility had reported insufficient heat. The vendor identified 5 of the 13 boilers in working order. Review of Vendor #1 Invoice no. 20241204, for a service call on [DATE], revealed boiler #6 had to be turned off which left 5 of 13 boilers functioning again. Review of Vendor #1 invoice no. 20241225 for service calls from [DATE] through [DATE], revealed there was insufficient heat in the building. On [DATE]the vendor billed for a mechanic and an assistant for 4 hours during the day to service PTAC units on the 6th Floor and noted there was an insufficient amount of hot water, due to some of the boilers not working. An additional service call was made on [DATE] when the facility placed a night call for lack of heat throughout the building. A Saturday call was made to the vendor on [DATE] when the facility again reported a lack of heat throughout the building. The invoice states boilers need to be serviced as soon as possible, as lack of heat is attributed to an insufficient number of boilers working. A service call was made on [DATE] to service PTAC units on the 6th Floor. (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	There was no documented evidence the facility's heating system equipment, including the boilers and Packaged Terminal Air Conditioners, was being inspected and maintained by facility staff. Observations during the initial tour of the facility on [DATE] from 9:00 AM to 11:30 AM revealed temperatures in resident rooms, corridors, and stairwells were below State and Federal required ranges. Temperatures were observed between ,d+[DATE] degrees Fahrenheit. The East, North, and South Stairwells were measured at 40 degrees Fahrenheit. The resident rooms located closest to the stairwells had the lowest temperature readings. On [DATE] at 1:15 PM, the Director of Maintenance was interviewed and stated the Packaged Terminal Air Conditioner units were not blowing hot air because they were connected incorrectly. The Director of Maintenance stated they made the Administrator aware of the issue. On [DATE] at 1:30 PM, the Administrator was interviewed and stated they were not aware there was loss of heat in the building or that resident room temperatures were below regulatory ranges. They were not aware temperatures in some rooms had dropped below 60 degrees Fahrenheit. The Administrator stated the Packaged Terminal Air Conditioner units were not necessary because the boiler provides heat. The Administrator stated they were not aware the boiler was also not providing heat. During an interview on [DATE] at 1:15 PM, Vendor #1, stated they serviced the boilers at the facility in [DATE] for an issue of no hot water. The vendor stated the boilers had several problems that stemmed from a lack of maintenance and were operating at about 40%. This contributed to the hot water not getting hot enough to provide hot water or heating for the building. The vendor stated several proposals were sent to the Administrator and the Director of Maintenance via email. The Vendor further stated they had serviced the boilers at the facility in previous years but had stopped because of unpaid bills. For them to return in [DATE], they were given a check for a past-due balance. On [DATE] at 1:00 PM, during a subsequent interview, the former Director of Maintenance stated that in the 6 months they were employed at the facility, they attempted to get the boilers serviced. They stated they called the vendor to schedule the services, but they would not come in because of overdue unpaid balances. The Director of Maintenance stated they referred those calls to the Administrator. The Director of Maintenance stated they were not allowed to order materials or services without prior approval from the Administrator. Immediate Jeopardy was identified, and the Administrator was notified on [DATE] at 7:25 PM. An acceptable immediate corrective action plan from the facility was received on[DATE], at 11:32 PM Immediate Jeopardy was removed prior to survey exit on [DATE] based on the following corrective actions taken by the facility: 1. Packaged Terminal Air Conditioner units were deployed to all affected areas. Residents were relocated to warmer areas of the facility and twice daily temperature checks of all residents' rooms were conducted by the facility. A review of the temperature logs from [DATE] to [DATE] revealed temperatures within acceptable ranges. 2. Extra blankets and clothing were distributed to the residents by Housekeeping and Activities staff, hot beverages were provided, and residents had the option of staying in the warmer common areas. (continued on next page)

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. The Administrator provided a vendor contract for annual boiler maintenance and the maintenance of Packaged Terminal Air Conditioner units. 4. The facility completed staff training on identifying and addressing temperature-related issues, procedures for reporting problems, deploying emergency measures, and ensuring resident comfort. 100% of staff received the in-service. 5. A Quality Assurance meeting was held on [DATE] to discuss the findings of the Immediate Jeopardy. Wall thermometers have been installed in residents' rooms and staff were given in-service education on reading the thermometers. 6. The Emergency Preparedness plan for Loss of Heat was revised to include immediate deployment of portable units and proactive monitoring and escalation processes for heating issues. 10 NYCRR 415.29(b)