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	03/10/2025

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 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. 49081 Based on record review and interviews conducted during an abbreviated survey (NY00373346), the facility did not ensure the designated resident's representative was notified of changes in the resident's condition. This was evident in one (1) out of four (4) residents sampled (Resident #1). Specifically, on 02/01/2025, Certified Nursing Assistant #1 informed License Practical Nurse #1 Resident #1's had a stuffy nose. On 02/01/2025, License Practical Nurse #1 documented Resident #1 had a low grade fever of 100.5-degree Fahrenheit, and was restlessness. The medical doctor and the family were not notified. The findings are: The Facility's Policy on Designated Representative Notifications reviewed 12/2024, documented the facility will notify the resident's approved representative as designated in their records. Resident #1 was admitted to the facility with diagnoses of Epilepsy, Non-Alzheimer's Dementia, Depression with Schizophrenia, Traumatic Brain Injury and Urinary/Fecal incontinence and Constipation. The Minimum Data Set (a resident assessment tool) dated11/23/2024, documented Resident #1 was severely cognitively impaired. Licensed Practical Nurse #2 documented in a nursing notes dated 02/01/2025 at 6:51 AM, Resident #1 was restlessness, and they were unable to take their vital signs. They further documented that Registered Nurse Supervisor #2 was notified and assessed Resident #1 for restlessness in bed. They documented that the body temperature was normal but was unable to check vital signs such as pulse, respirations and blood pressure because Resident #1 was restlessness. Licensed Practical Nurse #1 documented in a nursing note dated 02/01/2025 at 10:25 PM, Resident #1 was restless in bed, Resident #1 had an increase temperature of 100.5-degree Fahrenheit. Registered Nurse Supervisor #1 was notified. Resident #1 was given Tylenol for fever. There was no documented evidence that Resident #1's representative was notified on 02/01/2025 when Resident #1 was with restless and had an increased temperature. (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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(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	During an interview on 03/04/2025 at 11:56 AM, Certified Nursing Assistant #1 stated they worked on 02/01/2025 during the 3:00 PM-11:00 PM shift they observed Resident #1 look weaker and notified Licensed Practical Nurse #1. Certified Nursing Assistant #1 stated Resident #1 moved their bowel a small amount. During an interview on 03/03/2025 at 4:40 PM, Licensed Practical Nurse #1 who worked on 02/01/2025 during the 3:00 PM-11:00 shift, stated Resident #1 was observed with stuffy nose and restless in bed. The Registered Nurse Supervisor #1 was notified. The COVID -19 rapid test was done, and result was negative. Tylenol was given because Resident #1 had low grade fever of 100.5-degree Fahrenheit. There was no documented evidence that Resident #1 was reassessed after Tylenol was given on 02/01/2025 at 10:20 PM. During an interview on 03/05/2025 at 9:01 AM, Registered Nurse Supervisor #1 stated, they conducted an assessment on Resident #1 but does not remember if they documented in the medical record. Registered Nurse Supervisor #1 stated they tried to call the Medical Doctor but was unsuccessful. Registered Nurse Supervisor #1 stated the family was not notified because Resident #1 was not in distress. During an interview on 03/05/2025 at 10:23 AM, Director of Nursing stated, the nurses should have notified the doctor and the family when Resident #1 had fever and was restlessness. 10 NYCRR 415.3(e)(2)(ii)(b)

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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 0684

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49081

Based on record review, observation, and interviews conducted during an abbreviated survey (NY00373346), the facility did not ensure a comprehensive clinical assessment was done to identify changes in a resident's condition. The facility did not ensure residents receive treatment and care in accordance with professional standards of practice. This was evident in one (1) out of four (4) residents sampled (Resident #1). Specifically, on [DATE], Resident #1 was observed with stuffy nose, low grade fever of 100.5-degree Fahrenheit, and restlessness. There was no documented evidence that the medical doctor was informed of the resident's change in condition. Additionally, there was no documented evidence that the resident was assessed after the acetaminophen was administered. Resident #1expired on [DATE]/2025 at 9:49 AM due to cardiac arrest secondary to coronary artery disease. This resulted in actual harm to Resident #1 with the potential for serious injury, serious harm, serious impairment, or death that was not Immediate Jeopardy.

The findings are:

The facility's Policy and Procedure titled Change in Resident Condition dated ,d+[DATE], documented it is the facility's purpose to ensure timely identification, documentation, and appropriate response to any significant change in a resident's condition to maintain safety and quality of care. The resident will be monitored closely, and additional assessments will be conducted as needed.

Resident #1 was admitted to the facility with diagnoses of Non-Alzheimer's Dementia, Schizophrenia (chronic mental illness characterized by disruptions in thought, perception, emotion, and behavior), Traumatic Brain Injury with Epilepsy, and Urinary/Fecal incontinence and Constipation.

The Minimum Data Set (a resident assessment tool) dated [DATE], documented Resident #1 was severely cognitively impaired.

Licensed Practical Nurse #2 documented in a nursing note dated [DATE] at 6:51 AM, Resident #1's vital signs were not done due to Resident #1 being restless. Registered Nurse Supervisor #2 was notified and assessed Resident #1 for restlessness in bed. Their body temperature was normal, but they were unable to check vital signs secondary to restlessness.

A nursing note written by Licensed Practical Nurse #1 dated [DATE] at 10:25 PM, documented Resident #1 was restless in bed, and had increased temperature of 100.5-degree Fahrenheit. Registered Nurse Supervisor #1 was notified, and Resident #1 was given acetaminophen ordered as needed for fever.

There was no documented evidence that the Medical Doctor was notified of Resident #1's elevated temperature and restlessness in bed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Manor Nursing & Rehabilitation Center	700 White Plains Road Bronx, NY 10473

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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A nursing note written by Licensed Practical Nurse #3 dated [DATE] at 2:42 PM documented, around 8:53 AM, Licensed Practical Nurse #3 went in the day room to administer medication and observed Resident #1 sitting in recliner wheelchair with face down and arms flex down. Resident #1 was not moving, unable to palpate a pulse and pupils (black hole in the center of the eye) of the eye not moving. Resident #1 had an advance directive for a full code. Code Blue (an emergency alert system) was announced, and Resident #1 was taken to their room and Cardiopulmonary Resuscitation was initiated until the fire department and 911 (emergency medical number) arrived and took over. Resident #1 was pronounced expired on [DATE] at 9:49 AM, by Emergency Medical Services. During an interview on [DATE] at 9:14 AM, Resident #1's family (the complainant) stated an autopsy was requested because the facility did not provide details leading to Resident #1's death. During an interview on [DATE] at 11:06 AM, Medical Doctor #1 stated they were called on [DATE] approximately at 10:00 AM and notified that Resident #1 expired. Medical Doctor #1 stated Resident #1 expired due to cardiac arrest secondary to coronary artery disease. The Medical Doctor #1 further stated, they were not notified when Resident #1 had an increased temperature or was experiencing restlessness. During an interview on [DATE] at 11:56 AM, Certified Nursing Assistant #1 stated they worked on [DATE] during the 3:00 PM-11:00 PM shift and observed Resident #1 looked weaker and notified Licensed Practical Nurse #1. Certified Nursing Assistant #1 stated Resident #1 moved their bowel a small amount. During an interview on [DATE] at 4:40 PM, Licensed Practical Nurse #1 who worked on [DATE] during the 3:00 PM-11:00 PM shift, stated Resident #1 was observed with a stuffy nose and restlessness in bed. The Registered Nurse Supervisor #1 was notified. The COVID -19 rapid test was done, and the result was negative. Acetaminophen was given because Resident #1 had low grade fever of 100.5-degree Fahrenheit. During an interview on [DATE] at 9:01 AM, Registered Nurse Supervisor #1 stated they conducted assessment on Resident #1 but does not remember if they documented it in the medical record. Registered Nurse Supervisor #1 stated they tried to call the Medical Doctor but was unsuccessful. During an interview on [DATE] at 10:23 AM, Director of Nursing stated the nurses must notify the doctor and family when Resident #1 had fever and was restless. The Director of Nursing stated once acetaminophen was administered, there should have been a follow up assessment an hour after the medication was given. 10 NYCRR 415.12