

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  05/29/2025
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 0569</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews the facility failed to convey the personal funds accounts to the probate jurisdiction administering the residents' estates within 30 days of expiration for 2 (Residents #1 and #2) of 3 sampled residents.</p> <p>The findings include:</p> <p>The facility admission Agreement, with a revised date of 08/2023, documented refunds for the balance in the personal account, less amounts owed to Grand Manor, will be made to the resident after discharge. Following a resident's death, refunds will be made to the probate jurisdiction administering the resident's estate or by a New York small estate affidavit unless the funds are otherwise properly claimed by the Department of Social Services to recoup Medicaid payments.</p> <p>The Admission, Discharge, and Transfer Activity Detail Report documented Resident #1 expired on [DATE]. The Residents Funds Ledger documented there was no disbursement for remaining funds and final accounting sent to the Public Administrator until [DATE].</p> <p>The Admission, Discharge, Transfer Activity Detail Report documented Resident #2 expired on [DATE] and the Residents Funds Ledger documented there was no disbursement for remaining funds and final accounting sent to the Public Administrator until [DATE].</p> <p>On [DATE] at 2:08 PM, the Payable Coordinator was interviewed and stated remaining funds for expired residents must be transferred within 30 days of their death to the Public Administrator. They stated they review the Admission, Discharge, Transfer Activity Detail Report monthly to identify who was discharged or expired and who has a balance left. The Payable Coordinator was unable to explain why Residents #1 and #2's remaining funds were not transferred to the Public Administrator within 30 days.</p> <p>On [DATE] at 2:55 PM, the Administrator was interviewed and stated when a resident passes away, the funds have to be transferred to the individual responsible for their administration within 60 days of discharge or death. They stated the Business Office receives the notice of death and the accounting department reconciles the funds. The Administrator stated if there is a burial, the funds are distributed to the funeral home and the remaining funds are transferred to the Public Administrator.</p> <p>10 NYCRR 415.26(h)(5)(iv)</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews conducted during the Abbreviated Survey (NY00377759, NY00377846), the facility did not ensure that all alleged violations involving misappropriation of resident property were reported within 24 hours after the allegation was made to the State Survey Agency. Additionally, the facility did not ensure that the results of all investigations were reported to the State Survey Agency within five (5) working days of the incident. This was evident in three (3) of three (3) residents (Residents #4, #5, and #6) sampled for abuse. Specifically, 1.) On 4/07/2025 at 2:30 PM, Resident #4 reported that Patient Care Assistant #1 borrowed money from them to repay a loan from Resident #5. Resident #4 alleged that Patient Care Assistant #1 did not pay them back. The facility initially reported the misappropriation allegation to the New York State Department of Health on 04/11/2025 at 4:59 PM. In addition, the facility did not submit a Follow-Up Investigation Report within five (5) working days of the incident. 2.) On 04/11/2025 at 4:11 PM, Resident #6 reported that Certified Nursing Assistant #1 borrowed \$20.00 and did not pay them back. An initial report was made to the New York State Department of Health timely, but a Follow-Up Investigation Report was not submitted by the facility within five (5) working days of the incident.</p> <p>The findings are:</p> <p>A Dear Nursing Home Administrator Letter (DAL: NH 22-20) dated 10/18/2022 regarding Facility Incident Reporting System stated that the notice was to inform the Administrator of changes in reporting of nursing home facility incidents as detailed in QSO-22-19-NH and effective on 10/24/2022. The guidance stated that in addition to an initial facility incident report that must be submitted following reporting timelines, nursing homes must submit to the New York State Department of Health the results of the facility investigation. Within five (5) business days of the incident, the facility must provide, in its report, sufficient information to describe the results of the investigation, and must indicate any corrective action(s) taken if the allegation was verified. The facility should include any updates to information provided in the initial report and the following additional information, including, but not limited to: 1. Additional/Updated information related to the reported incident, 2. Steps taken to investigate the allegation, 3. A conclusion, 4. Corrective action(s) taken, and 5. The name of the facility investigator.</p> <p>The facility policy titled Abuse Prohibition &amp; Prevention, last revised 12/2024, documented all allegations or reasonable suspicions must be reported to a staff member's immediate supervisor, the Director of Nursing, and/or the Administrator immediately upon discovery and to the New York State Department of Health within two (2) hours. The facility initiates internal investigations immediately, to be completed within five (5) business days.</p> <p>1.) Resident #4 had diagnoses of depression and opioid abuse. The quarterly Minimum Data Set (a resident assessment tool) dated 12/21/2024 documented Resident #4 had intact cognition.</p> <p>Resident #5 had diagnoses of heart failure and opioid abuse. The admission Minimum Data Set, dated [DATE] documented Resident #5 had intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The undated facility's Final Summary and Conclusion of Investigation documented the investigation was initiated on or around 04/07/2025 after Resident #4 reported that Patient Care Assistant #1 allegedly borrowed \$15.00 from them several months earlier to pay back a \$20.00 loan that Patient Care Assistant #1 received from Resident #5 and failed to repay. According to Resident #4, this incident occurred three (3) to four (4) months prior to the report being made. Resident #5 denied lending any money to Patient Care Assistant #1. The facility investigation concluded due to the absence of clear, consistent, and corroborated evidence; the facility was unable to confirm that misappropriation occurred.</p> <p>The alleged misappropriation incident was initially reported to the New York State Department of Health on 04/11/2025 at 4:59 PM.</p> <p>A webform Nursing Home Investigative Report showed that the facility submitted the follow-up investigation report to the New York State Department of Health on 04/22/2025 at 5:06 PM.</p> <p>During an interview on 05/29/2025 at 9:54 AM, the Director of Nursing stated they were aware misappropriation allegations must be reported immediately but no longer than two (2) hours after the initial allegation to the New York State Department of Health. They stated they submitted the Follow-Up Investigative Report late because they needed more information. The Director of Nursing stated that based on their investigation, the alleged incident could not be substantiated because the statements were inconsistent.</p> <p>During an interview on 05/29/2025 at 10:56 AM, the Administrator stated they were not aware that allegations of misappropriation must be reported immediately but no longer than two (2) hours after the initial allegation to the New York State Department of Health. The Administrator stated the Director of Nursing should have submitted the Follow-Up Investigative Report within five (5) business days and they were not aware the report was submitted late.</p> <p>2.) Resident #6 had diagnoses of Cerebral Palsy (a group of conditions that affect movement and posture), Anxiety Disorder, and Hypertension. The quarterly Minimum Data Set, dated [DATE] documented Resident #6 had intact cognition.</p> <p>A Resident Occurrence Form dated 04/11/2025 at 4:30 PM documented Resident #6 reported that Certified Nursing Assistant #1 borrowed \$20.00 from them about two (2) months ago in February and never paid them back. The facility's Summary of Investigation dated 04/28/2025 documented that the facility investigation concluded Resident #6's allegation of misappropriation could not be proven as there were no witnesses at the time of the incident and Certified Nursing Assistant #1 denied borrowing money from Resident #6.</p> <p>The facility initially reported the alleged misappropriation to the New York State Department of Health on 04/11/2025 at 6:00 PM.</p> <p>A webform Nursing Home Investigative Report showed that the facility submitted the Follow-Up Investigation Report to the New York State Department of Health on 04/22/2025 at 10:09 PM.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on observation, record review, and interviews, the facility failed to thoroughly investigate all alleged violations involving abuse for one (1) (Resident #158) of five (5) sampled residents. Specifically, the Director of Recreation received a report from Resident #158 alleging they were threatened by an unidentified Certified Nursing Assistant. An investigation was not immediately initiated, and measures were not put in place to ensure further potential abuse did not occur.</p> <p>The findings are:</p> <p>The facility policy titled Abuse Prohibition &amp; Prevention with a last revised date of 12/2024 documented all allegations or reasonable suspicions must be reported to a staff member's immediate supervisor, and to the Director of Nursing and/or the Administrator immediately upon discovery. The facility initiates internal investigations immediately, to be completed within five (5) business days.</p> <p>Resident #158 had diagnoses of Multiple Sclerosis (a disease that causes breakdown of the protective covering of nerves), Hemiplegia (paralysis that affects only one side of your body), and Adjustment Disorder (excessive reactions to stress that involve negative thoughts, strong emotions and changes in behavior).</p> <p>The Minimum Data Set (a resident assessment tool) dated 03/26/2025 documented Resident #158 had intact cognition and required the assistance of one (1) to two (2) people to complete activities of daily living.</p> <p>On 05/23/2025 at 1:00 PM, Resident #158 was interviewed and stated about two (2) days ago, on two (2) separate occasions, during the evening and night shift, two (2) Certified Nursing Assistants threatened to slap them on the face if they pressed the call bell again. Resident #158 stated they reported this incident to the Director of Recreation and Registered Nurse #1, who was the nursing supervisor.</p> <p>An employee statement written by the Director of Recreation documented on 05/20/2025 while their shift was ending, Resident #158 reported that a Certified Nursing Assistant who worked from 11:00 PM - 7:00 AM shift threatened them. The statement documented Resident #158 was unable to provide the name of the staff member and the date the incident happened.</p> <p>The facility failed to provide documented evidence that an investigation was initiated to address Resident #158's allegation.</p> <p>On 05/27/2025 at 11:28 AM, the Director of Recreation was interviewed and stated they went to Resident #158's room on 05/20/2025 to give the resident a radio when the resident reported that a night shift Certified Nursing Assistant threatened them. The Director of Recreation stated they asked Resident #158 for more details, but the resident could not give the staff's name or date when the alleged incident occurred. They stated they did not immediately report the allegation because they did not have the information. The Director of Recreation stated they wrote a statement on that same day and placed it in Social Worker #1's mailbox. They stated they also placed a copy of the statement in the Director of Nursing's mailbox.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/27/2025 at 11:51 AM, Social Worker #1 was interviewed and stated they were not aware of Resident #158's allegation of abuse until 05/23/2025, as they do not check their mailbox daily. Social Worker #1 stated the Director of Recreation should have notified them of the alleged abuse right away so that the Director of Nursing could initiate the investigation.</p> <p>On 05/28/2025 at 11:22 AM, Registered Nurse #1 was interviewed and stated they had not received a report from Resident #158 that a staff threatened to hit them. They stated this was the first time they heard of the allegation.</p> <p>On 05/28/2025 at 02:47 PM, the Director of Nursing was interviewed and stated the Director of Recreation did not put a copy of their written statement in their mailbox. They stated they were only made aware of the allegation made by Resident #158 on 05/23/2025.</p> <p>The Director of Nursing stated the Director of Recreation should have immediately reported the allegation to the Administrator. The Director of Nursing stated they initiated the investigation on 05/23/2025 when they were told of the allegation.</p> <p>On 05/29/2025 at 10:56 AM, the Administrator was interviewed and stated they were made aware of Resident #158's allegation that a staff threatened them on 05/23/2025. They stated whenever there is an allegation of abuse, the immediate supervisor, the Director of Nursing, and the Administrator must be immediately notified so they can initiate the investigation.</p> <p>10 NYCRR 415.4(b)(3)</p>		