

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  12/09/2025
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)
F 0609  Level of Harm - 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)

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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F 0609  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews the facility failed to ensure all alleged violations involving injury of unknown source were reported immediately, but not later than two (2) hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury to the State Survey Agency. This was evident for one (1) (Resident #7) of four (4) sampled residents. Specifically, on 09/13/2025 Resident #7 was unable to stand on their left leg and was transferred to the hospital. The resident was readmitted to the facility on [DATE] with diagnoses of left femur (thigh bone) fracture (break in the bone). Resident #7 was severely impaired in cognition and was unable to explain how they sustained the fracture. The facility reported the injury of unknown source to the New York State Department of Health on 09/23/2025 at 11:53 PM, 10 days after the change in resident's condition was observed. The findings are: The facility policy titled Reporting Alleged Violations with a reviewed date of 03/2025 documented the purpose of the policy was to ensure that all alleged violations are reported immediately to the facility Administrator and other officials. The policy stated the facility must ensure all alleged violations involving abuse, neglect, exploitation or mistreatment must be reported immediately. This includes injury of unknown source and misappropriation of resident property. Resident #7 had diagnoses of Dementia (loss of memory), Type 2 Diabetes Mellitus (a condition affecting how the body regulates blood sugar), and Major Depressive Disorder (depression). The Quarterly Minimum Data Set (a resident assessment tool) dated 08/20/2025 documented Resident #7 had severely impaired cognition and required supervision or touching assist for transfers and ambulation. A nurse's progress note dated 09/13/2025 at 3:13 PM documented that Resident #7 was unable to stand on their left leg. The physician ordered to transfer the resident to the hospital. A nurse's progress note dated 09/22/2025 at 9:58 PM documented that Resident #7 was re-admitted from the hospital at about 2:20 PM. The admission diagnosis was closed left hip fracture (a break in the left hip bone that does not penetrate the skin). The facility's Summary of Investigation dated 09/23/2025 documented that on 09/13/2025 at around 1:00 PM, Certified Nursing Assistant #15 reported to Licensed Practical Nurse #1 that Resident #7 complained of left leg pain. The resident was assessed by Registered Nurse #9 with no visible injury, no redness, and no swelling. The resident was observed with weakness to the left leg and lethargic. The attending physician was notified and ordered to transfer the resident to the hospital and was admitted with diagnosis of closed left hip fracture. The summary of investigation documented that Resident #7 was unable to provide any history due to dementia, there was no reported fall or traumatic incident. The facility concluded that the hospital x-ray (a device that projects images) showed fracture of the left femur and vascular calcifications were present. The summary documented that vascular calcifications are common in the elderly and could lead to pathological fracture. There was no cause to believe that any alleged resident abuse, mistreatment or neglect had occurred. A review of Resident #7's facility and hospital medical records showed no documentation that the fracture was pathological. The Webform submission email confirmation dated 09/23/2025 at 11:55 PM documented the Nursing Home Facility Incident Report was successfully submitted on 09/23/2025 at 11:53 PM. On 12/09/2025 at 3:40 PM, the Director of Nursing was interviewed and stated Resident #7 was transferred to the hospital because they could not stand. They stated they followed up with the hospital, but the hospital would not disclose any information. The Director of Nursing stated Resident #7 returned to the facility on [DATE] but found out about the fracture the next day during the morning meeting. They stated they knew the injury has to be reported to the New York State Department of Health, but the nursing supervisor did not immediately notify them. They stated they reported the injury once they were informed. On 12/09/2025 at 3:45 PM, the Administrator was interviewed and stated they were not aware there was a delay in reporting. They stated the Quality Assurance committee will determine what caused the delay and they will conduct staff education on proper notification and will conduct audits to ensure that injuries are reported to the department heads and to the Department of Health. 10 NYCRR 415.4 (b)(2)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, record review, and interviews, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents. This was evident for one (1) of 11 residents (Resident #88) reviewed for accidents out of 35 total sampled residents. Specifically, Resident #88 who was identified as at risk for falls, was observed without floor mats and their bed not in the lowest position as stated in their care plan. The findings are: The facility's policy and procedure titled Falls Prevention with a revision date of 05/14/2023 documented that it is the policy of the facility to assess all residents for their fall risk potential and institute an appropriate plan of care designed to prevent/reduce falls. A Fall Risk Assessment Score totaling 21 or more places the resident at risk for falls and therefore a prevention protocol should be initiated immediately. The protocol plan of care is entered onto the resident's care plan. The licensed Nurse will use the established protocols for fall risk prevention as a basis for the resident's plan of care. The nurse will individualize the plan of care to meet the resident's need as appropriate. The facility's policy titled Managing Falls and Fall Risk with a revision date of 07/2025, documented that based on previous evaluations, and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The Interdisciplinary Team will identify appropriate interventions to reduce the risk of falls. If falling recurs despite initial interventions, the interdisciplinary team will implement additional or different interventions or indicate why the current approach remains relevant. The interdisciplinary team will identify and implement relevant interventions (for example bed/chair alarms, wheelchair cushions, perimeter mattress, floor mats) to try to minimize serious consequences of falling. Resident #88 had diagnoses that included schizoaffective disorder (severe mental illness that includes symptoms of both schizophrenia such as hallucinations and delusions) and mood disorders (such as depression or mania), dementia (loss of memory), and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 10/06/2025 documented Resident #88 had severely impaired cognition and had functional limitations in range of motion on both sides of the upper and lower extremities, utilized a manual wheelchair for mobility, was dependent for toileting hygiene, showers/bathing and required partial to moderate assist for sit to stand mobility, transfers and wheelchair locomotion. A care plan for falls was initiated for Resident #88 on 12/06/2016 and was last reviewed on 10/12/2025. The care plan documented Resident #88 was at risk for falls due to intermittent confusion, needs assistant for toilet and transfers, and psychiatric disorders. The facility interventions included to maintain bed position at the lowest level with bilateral floor mats on each side of bed. Further review of the falls care plan revealed that Resident #88 had falls on 05/07/2025 at 7:55 AM, when resident was found sitting on the floor next to their bed; on 09/30/2025 at around 4:00 PM when they were found sitting on the floor mat on the right side of their bed; and on 10/12/2025 when they were found sitting on the floor next to their bed. On 12/01/2025 at 10:35 AM, Resident #88 was observed in their room, sitting in bed with the door closed. The bed was observed at the highest position and there were no floor mats on either side of bed. On 12/01/2025 at 1:34 PM, Resident #88 was observed crawling in bed. The bed was elevated at the highest position. There were no floor mats on either side of bed. On 12/08/2025 at 5:05 PM, an interview was conducted with Certified Nursing Assistant #13, and they stated that Resident #88 was on their assignment. Resident #88's room was observed with Certified Nursing Assistant #13 who stated that there are no floor mats in the resident's room. On 12/09/2025 at 4:00PM, an interview was conducted with the Director of Nursing who stated that Resident #88 had history of multiple falls, is non-compliant, and gets up on their own. The Director of Nursing stated Resident #88 is on half hourly monitoring and that their care plan interventions include placing bed in lowest position and use of floor mats. They stated that the nursing supervisors are responsible for making rounds in the unit and ensuring that floor mats are in use or if the bed is in the lowest position. 10 NYCRR 415.12(h)(2)</p>		