

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  02/24/2026
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 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews conducted during the survey, the facility failed to establish and maintain a system to accurately reconcile, verify, and oversee methadone medications received from an external opioid treatment program. This was evident for 10 (Residents #2, 16, 28, 49, 50, 53, 114, 142, 146, 177) of 23 residents enrolled and receiving methadone (a long-acting opioid used to treat opioid use disorder) through an opioid treatment program. Specifically, a review of methadone administration records revealed 10 of 23 residents received dosages inconsistent with physician's orders. The licensed nurses reported the administration process of methadone doses obtained and intended for residents registered with an external opioid treatment program did not include medication-order reconciliation. In addition, the facility failed to provide a policy or procedure outlining the process for ensuring that the dosage and formulation of methadone supplied by external opioid treatment programs are consistent with facility physicians' orders. This resulted in no actual harm with a likelihood for serious harm that is Immediate Jeopardy to residents receiving methadone maintenance therapy. See F-760. The findings are: The undated facility policy titled, Controlled Substance Handling, documented that all controlled drugs will be subject to special receipt, handling and storage, disposal and record keeping. All controlled substances received shall be delivered to the nursing unit and logged into the official count by two (2) nurses: the nurse who received the delivery and the nurse in charge of the unit, to verify the count and log the receipt. A controlled drug accountability record shall be prepared when receiving and checking-in a controlled drug and includes the following information: name of resident, prescription number, date received, and quantity received. Immediately after a dose is administered, the licensed nurse administering the drug enters all the following information on the medication administration record: date and time of administration, dose administered and signature of the nurse administering the dose. A physical inventory of all controlled drugs is made at the change of each shift by two licensed nurses and is documented on an audit record. The undated facility policy titled, Medication Administration Policy Documentation-General, documented that medication administration and documentation shall occur in a timely and accurate manner. The electronic administration record shall serve as the source from which all medications are poured and administered and on which medication doses are charted. The licensed nurse assures the five rights: compares the resident's name, medication name, strength, route and dosage schedule on the medication administration record against the prescription label and to always check three times prior to administration of medication. The undated facility policy titled, Consultant Pharmacist, documented that the facility would contract a qualified pharmacist to provide consultant pharmacist services to maintain compliance with federal and state regulations for pharmaceutical services. The Consultant Pharmacist shall perform monthly medication regimen review by reviewing all active physician orders for each resident within the facility in accordance with the federal code. The</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  335744	Facility ID:  335744  If continuation sheet Page 1 of 10

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Consultant Pharmacist shall perform quality assurance audits monitoring medication storage areas throughout the facility for appropriate storage and handling of medications and shall report findings to the Director of Nursing. The policy also stated the Pharmacy Consultant shall assist in the development and revision of policies and procedures related to the use and handling of medications. The facility was unable to provide any documented agreement outlining coordination with the external opioid treatment programs. A review of methadone administration records for 10 of 23 residents revealed multiple methadone administrations with discrepancies of dosage between the physician's orders and the label on the medication bottles. 1. Resident #2 had diagnoses of endocarditis (inflammation of the inner lining of your heart valves) and opioid use disorder (a complex illness characterized by compulsive and harmful use of opioid drugs despite negative consequences). The Minimum Data Set (a resident assessment tool) dated 01/27/2026 documented that the resident had intact cognition and required partial assistance for activities of daily living. A physician's order dated 01/27/2026 documented methadone oral solution 60 milligrams daily. The methadone bottle was labeled methadone oral solution 70 milligrams daily. The electronic Medication Administration Record from 01/27/2026 to 02/11/2026 documented 60 milligrams of methadone oral solution was administered daily. 2. Resident #16 had diagnoses of heart failure (a long-term condition that affects the heart's ability to pump blood well), anemia (a condition in which the number of red blood cells concentration is lower than normal) and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and required supervision with activities of daily living. A physician's order dated 01/18/2026 documented methadone oral solution 115 milligrams daily. The methadone oral solution bottle was labeled with a dosage of 125 milligrams daily. The electronic Medication Administration Record from 01/18/2026 to 02/11/2026 documented 115 milligrams of methadone oral solution was administered daily. The controlled drug accountability record listed methadone oral solution 115mg as the medication obtained, stored, and dispensed for the resident from 01/18/2026 to 02/11/2026. 3. Resident #28 had diagnoses of anemia, asthma (a persistent respiratory condition, narrows airways, causing breathlessness and difficulty breathing) and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and required partial to moderate assistance for activities of daily living. A physician's order dated 01/23/2026 documented methadone oral solution 80 milligrams daily. The methadone oral solution bottle was labeled with a dosage of 90 milligrams daily. The electronic Medication Administration Record from 01/23/2026 to 02/11/2026 documented 80 milligrams of methadone was administered daily. 4. Resident #49 had diagnoses of anxiety disorder (an intense, excessive and persistent worry and fear about everyday situations), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and was independent with activities of daily living. A physician's order dated 02/05/2026 documented Methadone oral solution 40 milligrams daily. The methadone oral solution bottle was labeled with a dosage of 30 milligrams daily. The electronic Medication Administration Record from 10/01/2024 to 02/11/2026 documented 40 milligrams of methadone was administered daily. The controlled drug accountability record listed methadone oral solution 40 mg as the medication obtained, stored, and dispensed for the resident from 02/1/2026 to 02/11/2026. 5. Resident #50 had diagnoses of diabetes mellitus (a condition that affects blood sugar levels), hypertension (commonly known as high blood pressure) and opioid use Disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and required partial to moderate assistance with activities of daily living. A physician's order dated 06/26/2025 with a renewal date of 02/01/2026 documented methadone oral solution 95 milligrams daily. The methadone oral</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>solution bottle was labeled with a dosage of 85 milligrams daily. The electronic Medication Administration Record from 06/26/2025 to 02/11/2026 documented 95 milligrams of methadone was administered daily. 6. Resident #53 had diagnoses of coronary artery disease (general term for plaque buildup in the arteries), Hypertension, and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and required partial to moderate assistance with activities of daily living. A physician's order dated 01/08/2026 documented methadone oral solution 30 milligrams daily. The methadone oral solution bottle was labeled with a dosage of 24 milligrams daily. The electronic Medication Administration Record from 01/28/2026 to 02/11/2026 documented 30 milligrams of methadone was administered daily. The controlled drug accountability record listed Methadone Oral Solution 30mg as the medication obtained, stored and dispensed for the resident from 01/28/2026 to 02/11/2026. 7. Resident #114 had diagnoses of cerebral infarction (a medical condition where an area of brain tissue dies due to a lack of blood supply), schizophrenia (a serious brain disorder that causes people to interpret reality abnormally) and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had severely impaired cognition and was dependent with activities of daily living. A physician's order dated 11/18/2025 documented methadone oral solution 20 milligrams daily. The methadone oral solution bottle was labeled with a dosage of 30 milligrams daily. The electronic Medication Administration Record from 11/18/2025 to 02/10/2026 documented 20 milligrams of methadone was administered daily. 8. Resident #142 had diagnoses of anemia, benign prostatic hypertrophy (an enlarged prostate), and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and required substantial assistance for activities of daily living. A physician's order dated 11/06/2025 documented methadone oral solution 120 milligrams daily. The methadone oral solution bottle was labeled with a dosage of 130 milligrams daily. The electronic Medication Administration Record from 11/07/2025 to 02/11/2026 documented 120 milligrams of methadone was administered daily. 9. Resident #146 had diagnoses of hypertension, viral hepatitis (enlargement of the liver caused by a few specific viruses that primarily attack the liver), and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and was independent for activities of daily living. A physician's order dated 11/20/2023, with a renewal date of 02/01/2026 documented methadone oral solution 280 milligrams daily. The methadone oral solution bottle was labeled with a dosage of 295 milligrams daily. The electronic Medication Administration Record from 11/20/2023 to 02/11/2026 documented 280 milligrams of methadone was administered daily. 10. Resident #177 had diagnoses of coronary artery disease, heart failure and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and was dependent on activities of daily living. A physician's order dated 07/06/2022 with a renewal date of 02/01/2026 documented methadone oral solution 90 milligrams daily. The methadone oral solution bottle was labeled with a dosage of 80 milligrams daily. The electronic Medication Administration Record from 07/06/2022 to 02/12/2026 documented 90 milligrams of methadone was administered daily. The facility was unable to provide policy, procedure or documented evidence of reconciliation of clinic-supplied methadone doses. During an interview on 02/13/2026 at 11:03 AM, Licensed Practical Nurse #4 stated when administering methadone to the residents, they first check the physician's order in the electronic medical record and then administer the methadone labeled with the resident's name. They stated they do not cross-check the dosage listed on the methadone bottle against the physician's order. Licensed Practical Nurse #4 stated they had not noticed the discrepancies in dosages between the physician's orders and the dosage documented on the methadone bottle. Licensed Practical Nurse #4 stated they just realized that Residents #50 and #177's physician's order does not match the dosage on the</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>methadone bottles. They stated they should have paid more attention. During an interview on 02/11/2026 at 10:34 AM, Registered Nurse #2 stated that residents on methadone maintenance therapy are escorted to the methadone clinic to pick up the medication. The escort hands over the methadone to the nurse on the unit. The nurse then logs the number of methadone bottles received in the controlled drug accountability record and stores it in a locked box. Registered Nurse #2 stated they do not receive any paperwork from the methadone clinic to verify the number of methadone bottles and the dosage. They stated they check the resident's name on the bottle when they receive the methadone from the escort, but they do not check for any changes in the dosage. Registered Nurse #2 stated when administering methadone to the residents, they only check the resident's name on the bottle. They stated they do not check and compare the physician's order to the dosage listed on the bottle because they are familiar with the residents. During an interview on 02/13/2026 at 11:15 AM, Registered Nurse #10 stated the escort hands them the methadone bottles when they come back from the clinic with the resident. Registered Nurse #10 stated they would not know if there were any changes in the dosage as they do not receive any type of paperwork from the methadone clinic. They stated they never contacted the clinic to verify methadone orders. Registered Nurse #10 stated they administered 30 milligrams of methadone to Resident #114 as stated on the bottle. They stated they were not aware the dosage on the bottle was different from the physician's order. During an interview on 02/13/2026 at 11:35 AM, Registered Nurse #11 stated when administering methadone to the residents, they did not check if the dosage listed on the bottle accurately reflected the physician's order. They stated they would have notified the nursing supervisor if they noticed the discrepancy. Registered Nurse #11 stated they are unsure where methadone is delivered from, but stated they assumed that it was coming from a clinic. During an interview on 02/12/2026 at 11:33 AM, Attending Physician #1 stated they have residents who attend the outpatient methadone clinic where the physician from that clinic prescribes the dosage and frequency of methadone. They stated they do not receive any physical or electronic orders from the methadone clinic. Attending Physician #1 stated the licensed nurses enter the order from the label on the methadone bottles received from the clinic into the electronic medical record and then they sign the orders. They stated they are unsure what methadone dosage each resident is supposed to receive. However, the residents must receive the dosage indicated on the methadone bottle. Attending Physician #1 further stated that the physician's order and the dosage labeled on the methadone bottle do not necessarily need to match for the nurse to administer the medication. During an interview on 02/12/2026 at 10:11 AM, the Director of Nursing stated they have residents on methadone maintenance therapy who are escorted to the methadone clinic to pick up the medication. They stated the methadone clinic determines the methadone dosage and frequency for the residents. When the resident returns from the clinic, the escort hands the medication over to the unit nurse. The unit nurse calls the attending physician with the dosage then enters the order in the electronic medical record. The Director of Nursing stated there is no receipt or other paperwork received from the clinic that will alert the nurses if there is a change in the dosage. The Director of Nursing stated that the nurse who receives the methadone from the escort is responsible for ensuring that the methadone dose as listed on the prescription bottle matches the physician's order. During an interview on 02/19/2026 at 11:42 AM, the Pharmacy Consultant stated that the medication record reviews are conducted on medications that are dispensed from the pharmacy since the pharmacy is linked with the facility's electronic medical record. They stated there is no way for them to know if the physician's order for methadone is correct or if the order matches the prescribed dosage because methadone is dispensed from an outpatient clinic. During an interview on 02/11/2025 at 1:00 PM, the Medical Director stated they have</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>residents in the facility that are engaged in an external methadone maintenance program. They stated they did not know the process by which the methadone is delivered to the facility. They stated that the methadone dosage is determined by the methadone clinic. They stated the methadone clinic sends a report to the facility indicating the dosage and frequency for each resident, and the nurse enters it in the electronic medical record under physician's order. The Medical Director stated they electronically sign the orders without looking at the report. They stated their only responsibility is to assess the residents and renew the orders. During a follow-up interview with the Medical Director on 02/13/2026 at 2:51 PM, they indicated that the lack of established processes and communication between the facility and the methadone clinics represents a system failure. During an interview on 02/24/2026 at 2:46 PM, the Administrator stated the nurses are responsible for reconciling the physician's order and the methadone regimen as listed on the prescription bottles provided by the opioid treatment programs. They stated that the attending physicians should have performed monthly record review to ensure that there is no discrepancy between the physicians' orders and the methadone doses the residents are receiving. Immediate Jeopardy was identified, and the Director of Nursing was notified on 02/13/2026 at 6:49 PM. An acceptable immediate corrective action plan from the facility was received on 02/14/2026 at 8:50 PM. Immediate Jeopardy was removed prior to the survey exit of 02/24/2026 based on the following corrective actions taken by the facility: 1. The Director of Nursing reviewed all residents receiving methadone from an external opioid treatment program on 02/13/2026 . The review confirmed ten (10) residents (Residents #2, 16, 28, 49, 50, 53, 114, 142, 146, 177) with discrepancies of dosage between the physician's orders and the labeled methadone bottles. These 10 residents were clinically assessed and found to have no signs and symptoms of toxicity or any adverse reactions. 2. The Director of Nursing contacted each methadone clinic to confirm the current prescribed methadone dose and frequency. This was completed on 02/24/2026. 3. The Director of Nursing contacted the Medical Director and obtained telephone orders to ensure the physician's orders correspond with the doses on the methadone bottles. 4. The Pharmacy Consultant completed a regimen review of residents prescribed methadone on 02/18/2026. The audit revealed that all previous discrepancies were corrected and there were no other discrepancies identified. 5. A new policy and procedure on methadone administration, order verification, reconciliation, and chain of custody was created and reviewed by the Administrator, Medical Director, and the Director of Nursing. The facility's Methadone administration order verification and reconciliation policy, establishes a formal, documented chain-of-custody process for methadone received from the external opioid treatment programs. The procedure addresses the implementation of the Reconciliation and Chain of Custody Receipt Form which documents methadone disposition from the methadone clinic to the facility. The methadone clinic program is now required to complete the reconciliation and chain of custody form when providing methadone bottles to the facility/escort, accounting for the number of bottles dispensed and any changes in the dosage or frequency of methadone as prescribed by the program. Upon facility receipt of the form and the medication on the unit, the license nurse will reconcile the received medication with the facility physician's order. In the event a discrepancy is identified, the licensed nurse will notify the RN supervisor to contact the opioid treatment program to verify the change. The RN supervisor will notify the attending physician and request an updated and accurate medication order. The discrepancy and resolution will be documented in nursing progress notes in the electronic medical record. The receipt of Methadone disposition will be signed by the escort upon receipt at the location of the program and will be signed by the receiving licensed nurse at the facility. The licensed nurse will provide the Reconciliation and Chain of Custody Receipt Form to the Registered Nurse Supervisor and will be filed in</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>a binder to be kept in the nursing office for record and verification. This policy was effective on 02/14/2026.6. All licensed nurses, attending physicians, the pharmacy consultant, and the facility escorts received in-service on the new policy. 10 New York Codes, Rules, and Regulations 80.7510 New York Codes, Rules, and Regulations 415.18(a)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews conducted during the survey, the facility failed to ensure medications were administered in accordance with physician's orders. This was evident for 10 (Residents #2, 16, 28, 49, 50, 53, 114, 142, 146, 177) of 23 residents on methadone (a long-acting opioid medication that is used to reduce withdrawal symptoms in people addicted to heroin or other narcotic drug) maintenance therapy. Specifically, the facility administered methadone doses that differed from the physician ordered dose resulting in significant medication errors. See F-755. The findings are: The undated facility policy titled Medication Administration Policy Documentation-General, documented that medication administration and documentation shall occur in a timely and accurate manner. The electronic administration record shall serve as the source from which all medications are poured and administered and on which medication doses are charted. The licensed nurse assures the five rights: compares the medication name, strength, route and dosage schedule on the medication administration record against the prescription label and to always check three times prior to administration of medication. A review of methadone administration records identified 10 of 23 residents were administered methadone with discrepancies between the physician's orders and the labeled dose on the medication bottle. 1. Resident #2 had diagnoses of endocarditis (inflammation of the inner lining of your heart valves) and opioid use disorder (a complex illness characterized by compulsive and harmful use of opioid drugs despite negative consequences). The Minimum Data Set (a resident assessment tool) dated 01/27/2026 documented that the resident had intact cognition and required partial assistance for activities of daily living. A physician's order dated 01/27/2026 documented methadone 60 milligrams daily. The methadone bottle was labeled 70 milligrams daily. The electronic Medication Administration Record from 01/27/2026 to 02/11/2026 documented 60 milligrams of methadone was administered daily. 2. Resident #16 had diagnoses of heart failure (a long-term condition that affects the heart's ability to pump blood well), anemia (a condition in which the number of red blood cells concentration is lower than normal) and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and required supervision with activities of daily living. A physician's order dated 01/18/2026 documented methadone 115 milligrams daily. The methadone bottle was labeled 125 milligrams daily. The electronic Medication Administration Record from 01/18/2026 to 02/11/2026 documented 115 milligrams of methadone was administered daily. 3. Resident #28 had diagnoses of anemia, asthma (a persistent respiratory condition, narrows airways, causing breathlessness and difficulty breathing) and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and required partial to moderate assistance for activities of daily living. A physician's order dated 01/23/2026 documented methadone 80 milligrams daily. The methadone bottle was labeled 90 milligrams daily. The electronic Medication Administration Record from 01/23/2026 to 02/11/2026 documented 80 milligrams of methadone was administered daily. 4. Resident #49 had diagnoses of anxiety disorder (an intense, excessive and persistent worry and fear about everyday situations), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and was independent with activities of daily living. A physician's order dated 02/05/2026 documented Methadone 40 milligrams daily. The methadone bottle was labeled 30 milligrams daily. The electronic Medication Administration Record from 10/01/2024 to 02/11/2026 documented 40 milligrams of methadone was administered daily. 5. Resident #50 had diagnoses of diabetes mellitus (a condition that affects blood sugar levels), Hypertension (commonly known as high blood pressure) and opioid use disorder. The Minimum Data Set, dated [DATE]</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>documented that the resident had intact cognition and required partial to moderate assistance with activities of daily living. A physician's order dated 06/26/2025 with a renewal date of 02/01/2026 documented methadone 95 milligrams daily. The methadone bottle was labeled 85 milligrams daily. The electronic Medication Administration Record from 06/26/2025 to 02/11/2026 documented 95 milligrams of methadone was administered daily. 6. Resident #53 had diagnoses of coronary artery disease (general term for plaque buildup in the arteries), hypertension, and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and required partial to moderate assistance with activities of daily living. A physician's order dated 01/08/2026 documented methadone 30 milligrams daily. The methadone bottle was labeled 24 milligrams daily. The electronic Medication Administration Record from 01/28/2026 to 02/11/2026 documented 30 milligrams of methadone was administered daily. 7. Resident #114 had diagnoses of cerebral infarction (a medical condition where an area of brain tissue dies due to a lack of blood supply), schizophrenia (a serious brain disorder that causes people to interpret reality abnormally) and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had severely impaired cognition and was dependent on activities of daily living. A physician's order dated 11/18/2025 documented methadone 20 milligrams daily. The methadone bottle was labeled 30 milligrams daily. The electronic Medication Administration Record from 11/18/2025 to 02/10/2026 documented 20 milligrams of methadone was administered daily. 8. Resident #142 had diagnoses of anemia, benign prostatic hypertrophy (an enlarged prostate), and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and required substantial assistance for activities of daily living. A physician's order dated 11/06/2025 documented methadone 120 milligrams daily. The methadone bottle was labeled 130 milligrams daily. The electronic Medication Administration Record from 11/07/2025 to 02/11/2026 documented 120 milligrams of methadone was administered daily. 9. Resident #146 had diagnoses of hypertension, viral hepatitis (enlargement of the liver caused by a few specific viruses that primarily attack the liver), and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and was independent for activities of daily living. A physician's order dated 11/20/2023, with a renewal date of 02/01/2026 documented Methadone 280 milligrams daily. The methadone bottle was labeled 295 milligrams daily. The electronic Medication Administration Record from 11/20/2023 to 02/11/2026 documented 280 milligrams of methadone was administered daily. 10. Resident #177 had diagnoses of coronary artery disease, heart failure and opioid use disorder. The Minimum Data Set, dated [DATE] documented that the resident had intact cognition and was dependent on activities of daily living. A physician's order dated 07/06/2022 with a renewal date of 02/01/2026 documented methadone 90 milligrams daily. The methadone bottle was labeled 80 milligrams daily. The electronic Medication Administration Record from 07/06/2022 to 02/12/2026 documented 90 milligrams of methadone was administered daily. During an interview on 02/13/2026 at 11:03 AM, Licensed Practical Nurse #4 stated when administering methadone to the residents, they first check the physician's order in the electronic medical record and then administer the methadone labeled with the resident's name. They stated they do not cross-check the dosage listed on the methadone bottle against the physician's order. Licensed Practical Nurse #4 stated they had not noticed the discrepancies between the physician's order and the dosage documented on the methadone bottle. Licensed Practical Nurse #4 stated they just realized that Residents #50 and #177's physician's order does not match the dosage on the methadone bottles. They stated they should have paid more attention. During an interview on 02/11/2026 at 10:34 AM, Registered Nurse #2 stated when administering methadone to the residents, they only check the resident's name on the bottle. They stated they do not check the physician's order and the dosage listed on the</p> <p>(continued on next page)</p>		

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  02/24/2026
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.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>bottle because they are familiar with the residents. Registered Nurse #2 stated they were aware they were supposed to ensure that the dosage on the methadone bottle matches the physician's order to prevent medication error. During an interview on 02/13/2026 at 11:15 AM, Registered Nurse #10 stated they administered 30 milligrams of methadone to Resident #114 as stated on the bottle. They stated they only followed the dosage on the bottle and had not noticed that it was different from the physician's order. During an interview on 02/13/2026 at 11:35 AM, Registered Nurse #11 stated when administering methadone to the residents, they only followed the dosage on the bottle. They stated they had not noticed that the dosage on the methadone bottle differed from the physician's order. They stated they would have notified the nursing supervisor if they noticed the discrepancy. During an interview on 02/12/2026 at 11:33 AM, Attending Physician #1 stated the methadone clinic prescribes the dosage and frequency of methadone. They stated they do not receive any physical or electronic orders from the methadone clinic. Attending Physician #1 stated the licensed nurses enter the order from the label on the methadone bottles received from the clinic into the electronic medical record and they then sign the orders. They stated they are unsure what methadone dosage each resident is supposed to receive. However, the residents must receive the dosage indicated on the methadone bottle. Attending Physician #1 further stated that the physician's order and the dosage labeled on the methadone bottle do not necessarily need to match for the nurse to administer the medication. During an interview on 02/12/2026 at 10:11 AM, the Director of Nursing stated the methadone clinic determines the methadone dosage and frequency for the residents. They stated the resident is escorted to the methadone clinic to pick up the medication. When they return, they hand the medication over to the unit nurse. The unit nurse calls the attending physician with the dosage then enters the order in the electronic medical record. The Director of Nursing stated there is no receipt or other paperwork received from the clinic. During an interview on 02/11/2026 at 1:00 PM, the Medical Director stated they have residents in the facility that are on a methadone maintenance program. They stated they do not know the process by which the methadone is delivered to the facility. They stated that the methadone dosage is determined by the methadone clinic. They stated the methadone clinic sends a report to the facility indicating the dosage and frequency for each resident, and the nurse enters it in the electronic medical record under physician's order. The Medical Director stated they electronically sign the orders without looking at the report. They stated their only responsibility is to assess the residents and renew the orders. During a follow-up interview with the Medical Director on 02/13/2026 at 2:51 PM, they indicated that the lack of established processes and communication between the facility and the methadone clinic represents a system failure. 10 New York Codes, Rules, and Regulations 415.12 (m)(2)</p>		

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  02/24/2026
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.			
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<p>F 0841</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.</p> <p>Based on observations, record reviews, and interviews conducted during the survey, the medical director failed to collaborate with the facility to develop procedures for the safe and accurate provision of medications. Specifically, the medical director failed to ensure that current standards of practice were followed regarding the development and implementation of policies to reconcile, verify, and oversee methadone medications received from external opioid treatment programs. The findings are: Please refer to F755 and F760. The facility's policy titled Physician Visits and Physician Delegation with a reviewed date of 01/2026 stated that the medical director's role is to provide oversight of medical care practices and regulatory compliance programs; and to oversee clinical standards. During an interview on 02/12/2026 at 11:33 AM, Attending Physician #1 stated they have residents on methadone maintenance program. They stated they are unsure what methadone dosage each resident is supposed to receive. However, the residents must receive the dosage indicated on the methadone bottle. Attending Physician #1 further stated that the physician's order and the dosage labeled on the methadone bottle do not necessarily need to match for the nurse to administer the medication. During an interview on 02/11/2025 at 1:00 PM, the Medical Director stated they have residents in the facility that are on methadone maintenance programs. They stated they did not know the process by which the methadone is delivered to the facility. They stated that the methadone dosage is determined by the methadone clinic. They stated the methadone clinic sends a report to the facility indicating the dosage and frequency for each resident, and the nurse enters it in the electronic medical record under physician's order. The Medical Director stated they electronically sign the orders without looking at the report and that their only responsibility is to assess the residents and renew the orders. During a follow-up interview with the Medical Director on 02/13/2026 at 2:51 PM, they indicated that the lack of established processes and communication between the facility and the methadone clinic represents a system failure. 10 New York Codes, Rules, and Regulations 415.15 (a)</p>		