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	06/30/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on record review and interviews, the facility failed to ensure that a resident or their representative was afforded the opportunity to participate in their care planning process. This was evident in one (Resident #101) of five residents reviewed for resident rights related to care planning out of 29 total sampled residents. Specifically, the facility failed to provide documentation that advance notice was provided to Resident #101's designated representative, or attempted to be provided, before the care plan meetings occurred.The findings include:The facility's policy titled Care Plan, reviewed January 2026, stated that the facility will develop and maintain a comprehensive, person-centered care plan based on the resident's assessment, goals, preferences, strengths, needs, and clinical condition. The policy further stated that the resident and/or the resident's designated representative will be encouraged to participate in the care planning process, as appropriate.Resident #101 had diagnoses including dementia (loss of thinking, memory, and reasoning abilities), Type 2 diabetes (a condition where the body has trouble managing blood sugar), and epilepsy (repeated uncontrolled electrical activity in the brain that leads to rapid muscle contractions).The Minimum Data Set (a resident assessment tool) dated 03/25/2026 documented severe cognitive impairment and indicated that involvement of a family member in care discussions was very important to the resident.A psychiatry evaluation dated 06/06/2026 documented that Resident #101 lacked decision-making capacity.Social work progress notes dated 01/05/2026 and 04/14/2026 documented that interdisciplinary care plan meetings were conducted in the resident's room and stated that the designated representative was invited but did not attend.The facility was unable to provide documented evidence demonstrating that Resident #101's designated representative received advance notice of either care plan meeting or that staff attempted to provide advance notice before the meetings occurred.During an interview on 06/25/2026 at 6:23 PM, Resident #101's designated representative stated they had not been invited to any care plan meetings and would have wanted to participate in the resident's care planning.During an interview on 06/26/2026 at 11:21 AM, the Director of Social Services stated they telephoned Resident #101's designated representative before each quarterly care plan meeting; however, the designated representative did not answer the calls. The Director of Social Services stated this notification attempts were not documented and stated they should have been documented.10 New York Codes, Rules, Regulations 415.11(c)(2)(ii)

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents or their designated representatives received quarterly personal funds account statements. This was evident in three (Residents #15, 74, and #101) of five residents reviewed for personal funds out of 29 total sampled residents. Specifically, the facility was unable to provide documentation demonstrating quarterly personal funds account statements were provided to the designated representatives of Residents #74 and #101 for the quarters ending 06/30/2025, 09/30/2025, 12/31/2025, and 03/31/2026, and to Resident #15's designated representative for the quarters ending 09/30/2025 and 12/31/2025.The findings include:The facility policy titled Resident Banking and Personal Funds, reviewed January 2026, stated the facility is responsible for managing and accounting for resident personal funds in accordance with applicable regulations and that quarterly account statements shall be provided to the resident or the resident's designated representative.1. Resident #101 had diagnoses including dementia (loss of thinking, memory, and reasoning abilities), Type 2 diabetes (a condition where the body has trouble managing blood sugar), and epilepsy (repeated uncontrolled electrical activity in the brain that leads to rapid muscle contractions).The Minimum Data Set (a resident assessment tool) dated 03/25/2026 documented severe cognitive impairment and indicated that involvement of a family member in care discussions was very important to the resident.The resident face sheet identified Resident #101's designated representative as the resident's first contact and next of kin.The facility failed to provide documentation demonstrating quarterly personal funds account statements were provided to Resident #101's designated representative for the quarters ending 06/30/2025, 09/30/2025, 12/31/2025, and 03/31/2026.During an interview on 06/25/2026 at 6:23 PM, Resident #101's designated representative stated they were unaware the resident maintained a personal funds account at the facility, had never received quarterly account statements. 2. Resident #15 had diagnoses including Alzheimer's disease (a condition that affects the brain and makes it harder for a person to think, remember, and carry out everyday tasks) and dysphagia (difficulty swallowing) following a cerebral infarction (stroke), and bipolar disorder (a form of mental illness where the affected individual experiences episodes of mood fluctuations).The Minimum Data Set, dated [DATE] documented that Resident #15 had severe cognitive impairments and considered personal belongings, clothing choice, and family involvement in care discussions very important.The resident face sheet identified Resident #15's designated representative as the resident's first contact and next of kin.The facility failed to provide documentation demonstrating quarterly personal funds account statements were provided to Resident #15's designated representative for the quarters ending 09/30/2025 and 12/31/2025.During an interview on 06/29/2026 at 9:18 AM, Resident #15's designated representative stated they did not regularly receive quarterly account statements and were unaware of purchases that had been made using the resident's personal funds. 3. Resident #74 had diagnoses including Alzheimer's disease, schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and severe chronic kidney disease (a long-term condition where your kidneys gradually lose their ability to filter waste and extra fluid from your blood).The Minimum Data Set, dated [DATE] documented that Resident #74 had severe cognitive impairments and was unable to report preferences related to clothing choice, family involvement in care discussions, and care of personal belongings.The resident face sheet identified Resident #74's designated representative as the resident's primary contact, emergency contact, and next of kin.The facility failed to provide documentation demonstrating quarterly personal funds account statements were provided to Resident #74's designated representative for the quarters ending 06/30/2025, 09/30/2025, 12/31/2025, and 03/31/2026.During an interview on 06/26/2026 at 5:46 PM, Resident #74 designated representative stated they were the primary contact for Resident #74 and had never received quarterly account (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	statements from the facility. The designated representative stated statements had occasionally been mailed to another individual listed in the face sheet who was not the primary contact; however, this individual also does not receive the statements on a quarterly basis.During an interview on 06/29/2026 at 10:50 AM, the Director of Social Services stated they were responsible for providing quarterly personal funds account statements to residents or their designated representatives. They stated cognitively intact residents received statements directly, while statements for cognitively impaired residents were mailed to their designated representatives. The Director of Social Services stated they believed statements had been mailed to the designated representatives of Residents #15 and #74 but were unable to provide documentation verifying they had been sent. They further stated quarterly statements were not mailed to Resident #101's designated representative because no mailing address was on file.During a follow-up interview on 06/30/2026 at 11:10 AM, the Director of Social Services stated they did not verify that quarterly statements were mailed to the resident's designated primary contact.During an interview on 06/30/2026 at 1:09 PM, the Administrator stated the Director of Social Services was responsible for mailing quarterly statements to the resident's designated primary contact and documenting compliance by retaining a photocopy of the dated mailing envelope.New York Codes, Rules, Regulations 415.26(h)(5)(ii)(a-c)

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure designated representatives of cognitively impaired residents were notified when resident personal funds accounts approached or exceeded the Supplemental Security Income resource limit. This was evident in two (Residents #74 and #101) of five residents reviewed for personal funds out of 29 total sampled residents. Specifically, the facility failed to provide documented evidence that designated representatives were notified, or that attempts to notify them were made, when resident personal fund balances reached or exceeded the Supplemental Security Income resource limit.The findings include:The facility's policy and procedure titled Resident Banking and Personal Funds , last reviewed January 2026, stated that Medicaid residents shall be notified when their personal funds account balance reaches $200 less than the Supplemental Security Income (SSI) resource limit for one individual.The Centers for Medicare and Medicaid Services Informational Bulletin dated 12/09/2025 documented that the Supplemental Security Income Resource Standard for 2026 was $2,000 per individual.1. Resident #101 had diagnoses including dementia (loss of thinking, memory, and reasoning abilities), epilepsy (repeated uncontrolled electrical activity in the brain that leads to rapid muscle contractions), and Type 2 diabetes (a condition where the body has trouble managing blood sugar).The Minimum Data Set (a resident assessment tool) dated 03/25/2026 documented severe cognitive impairment and indicated that involvement of a family member in care discussions was very important to the resident.A psychiatry evaluation dated 06/06/2026 documented that Resident #101 lacked decision-making capacity.The Resident Funds Ledgers for the quarters ending 06/30/2025, 09/30/2025, and 12/31/2025 documented account balances more than $2,000, exceeding the Supplemental Security Income resource limit.The facility failed to provide documentation demonstrating Resident #101's designated representative was notified, or that attempts were made to notify the designated representative, when the resident's account approached or exceeded the Supplemental Security Income resource limit.During an interview on 06/25/2026 at 6:23 PM, Resident #101's designated representative stated they were unaware the facility managed the resident's personal funds and had never been contacted regarding the resident's personal funds account. 2. Resident #74 had diagnoses including Alzheimer's disease (a condition that affects the brain and makes it harder for a person to think, remember, and carry out everyday tasks), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and severe chronic kidney disease (a long-term condition where your kidneys gradually lose their ability to filter waste and extra fluid from your blood).The Minimum Data Set, dated [DATE] documented that Resident #74 had severe cognitive impairments and was unable to report preferences related to clothing choice, family involvement in care discussions, and care of personal belongings.The Resident Funds Ledgers for the quarters ending 06/30/2025, 09/30/2025, 12/31/2025, and 03/31/2026 documented account balances more than $2,000, exceeding the Supplemental Security Income resource limit.The facility failed to provide documented evidence demonstrating Resident #74's designated representative was notified, or that attempts were made to notify the designated representative, when the resident's account approached or exceeded the Supplemental Security Income resource limit.During an interview on 06/26/2026 at 5:46 PM, Resident #74designated representative stated they were the resident's primary contact, and they expected to receive financial information from the facility. The designated representative stated they had not received communications regarding Resident #74 personal funds account.During an interview on 06/30/2026 at 3:35 PM, the Director of Social Services stated they were responsible for notifying designated representatives when a cognitively impaired resident's personal funds account was within $200 of the Supplemental Security Income resource limit. They stated notification attempts for Resident #101 were not documented and they believed Resident #74 designated representative had been notified; however, documentation of notification or attempted notification was not available.New York Codes, Rules, Regulations 415.26(h)(5)(i)(a)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure residents were free from misappropriation of property. This was evident in three (Residents #15, #74, and #101) of five residents reviewed for personal funds out of 29 total sampled residents. Specifically, the facility authorized withdrawals from the personal fund accounts of cognitively impaired residents to purchase clothing and shoes without documented authorization from their designated representatives. The findings include:The facility's policy titled Resident Purchases and Clothing, last reviewed January 2026, stated that when a resident lacks decision-making capacity, reasonable efforts will be made to notify the resident's designated representative of identified clothing or personal item needs and provide the representative with the opportunity to obtain the requested items. When reasonable efforts to contact the representative are unsuccessful, purchases using resident funds may be made only in accordance with facility policy and applicable regulations.The facility's policy and procedure titled Resident Banking and Personal Funds, last reviewed 01/2026, stated that charges shall only be made for items or services requested by the resident or the resident's designated representative.1. Resident #101 had diagnoses including dementia (loss of thinking, memory, and reasoning abilities), Type 2 diabetes (a condition where the body has trouble managing blood sugar), and epilepsy (repeated uncontrolled electrical activity in the brain that leads to rapid muscle contractions).The Minimum Data Set (a resident assessment tool) dated 03/25/2026 documented severe cognitive impairment and indicated that involvement of a family member in care discussions was very important to the resident.A psychiatry evaluation dated 06/06/2026 documented that Resident #101 lacked decision-making capacity.The Resident Funds Ledger documented withdrawals of $350.70 for six sweat suits, six knee-high socks, and three colored T-shirts on 07/23/2025; $421.66 for five sweat suits, five colored T-shirts, six knee-high socks, and one coat on 01/28/2026; and $149.99 for one pair of extra-depth shoes on 03/10/2026 from Resident #101's account. The withdrawals totaled $922.35.The facility was unable to provide inventory records for items purchased on 01/28/2026 and 03/10/2026. During an observation of Resident #101's room on 06/25/2026 at 10:59 AM with Certified Nursing Assistant #1, the clothing and shoes identified on the purchase invoices were not observed in the resident's room or on the resident. During an interview on 06/25/2026 at 6:23 PM, Resident #101's designated representative stated the resident was unable to make financial decisions, no authorization had been given for the purchases, and the facility had not notified them that additional clothing was needed. 2. Resident #15 had diagnoses including Alzheimer's disease (a condition that affects the brain and makes it harder for a person to think, remember, and carry out everyday tasks), bipolar disorder (a form of mental illness where the affected individual experiences episodes of mood fluctuations), and dysphagia (difficulty swallowing) following a cerebral infarction (stroke).The Minimum Data Set, dated [DATE] documented that Resident #15 had severe cognitive impairments and considered personal belongings, clothing choice, and family involvement in care discussions very important.The Resident Funds Ledger documented withdrawals of $317.76 for six sweat suits and six knee-high socks on 07/23/2025; $356.76 for five sweat suits, six knee-high socks, and one comforter on 01/28/2026; and $149.99 for one pair of extra-depth shoes on 03/10/2026 from Resident #15's account. The withdrawals totaled $824.51. The facility failed to provide documentation demonstrating Resident #15's designated representative authorized the purchases or that inventory records were completed for the purchased items.During an observation of Resident #15's room and interview on 06/29/2026 at 9:25 AM, Certified Nursing Assistant #1 stated many belongings had been packed because of the facility's impending closure but did not recall Resident #15 ever receiving the comforter purchased with resident funds. No comforter was observed being used by the resident.During an interview on 06/29/2026 at 9:18 AM, Resident #15's designated representative stated the facility had not requested permission to make the purchases, and they would not have (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	authorized the expenditures. 3. Resident #74 had diagnoses including Alzheimer's disease, schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and severe chronic kidney disease (a long-term condition where your kidneys gradually lose their ability to filter waste and extra fluid from your blood).The Minimum Data Set, dated [DATE] documented that Resident #74 had severe cognitive impairments and was unable to report preferences related to clothing choice, family involvement in care discussions, and care of personal belongings.The Resident Funds Ledger documented withdrawals of $394.62 for six sweat suits, seven colored T-shirts, and six knee-high socks on 07/23/2025; $454.72 for seven sweat suits, six knee-high socks, and one coat on 01/28/2026; and $149.99 for one pair of extra-depth shoes on 03/10/2026. The withdrawals totaled $999.33.The facility failed to provide documented evidence demonstrating Resident #74's designated representative authorized the purchases or that inventory records were completed for the purchased items.During an interview on 06/26/2026 at 5:46 PM, Resident #74's designated representative stated the family routinely supplied clothing and that the facility had not requested permission to purchase additional clothing using resident funds. They stated they were unaware that purchases had been made for the resident.During an interview on 06/30/2026 at 10:15 AM, the Accounts Payable Coordinator stated they are responsible for reviewing purchases made for the residents and that payment to the clothing vendor was issued after invoices containing two staff signatures were reviewed and approved. They stated that the signatures on the invoice are proof that the items were received by the residents.During an interview on 06/30/2026 at 11:20 AM, the Director of Social Services stated the facility used an outside vendor to purchase clothing for residents and acknowledged that designated representative authorization for purchases was not consistently documented. They stated if the resident's designated representative could not be reached, they would act as the resident's advocate and would authorize the clothing purchase using the resident's personal funds. The Director of Social Services stated that the Administrator's approval is needed before any withdrawals can be made from the resident's personal funds. They stated they had not contacted Resident 101's designated representative because the designated representative had not answered their phone in the past when they tried to get in contact. They believed they received verbal consent from Residents #15 and #74 designated representative to make the purchases but failed to document. The Director of Social Services stated they believed the ordered items had been delivered to the residents. They could not explain why inventory documentation was not completed and purchased items could not be located.During an interview on 06/30/2026 at 12:09 PM, the Director of Nursing stated designated representatives of cognitively impaired residents should provide permission before purchases were made using resident funds and acknowledged donated clothing was available for resident use. The Director of Nursing also stated inventory forms should have been completed when purchased items were delivered.During an interview on 06/30/2026 at 01:09 PM, the Administrator stated purchases for cognitively impaired residents should not occur without representative authorization. 10 New York Codes, Rules, Regulations 415.4(b)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that allegations of abuse and an injury of unknown origin were thoroughly investigated. This was evident in three (Resident #164, #32, and #132) of four residents reviewed for abuse out of 29 total sampled residents. Specifically, 1.) The facility failed to conduct thorough investigation after Resident #164 was transferred to the hospital on [DATE] for complaints of chest pain radiating to the left side and was subsequently diagnosed with rib fractures (broken bone). In addition, the facility failed to document findings to determine whether abuse, neglect, or other factors contributed to the injury. 2.) The facility failed to conduct a thorough investigation of a resident-to-resident altercation involving Residents #32 and #132 on 04/23/2026. The findings include: The facility's policy titled Abuse Prohibition and Prevention, last reviewed December 2023, stated the facility is responsible for the prompt and thorough investigation of alleged violations and occurrences. The policy requires written statements from all parties involved and from all staff on the unit at the time of the incident, as well as statements from non-staff witnesses within 24 hours. 1. Resident #164 had diagnoses that included Alzheimer's disease (a brain disorder that slowly affects memory, thinking, and the ability to do everyday tasks), vitamin D deficiency (when your body doesn't have enough vitamin D), and anemia (a condition when blood doesn't have enough healthy red blood cells to carry oxygen around the body). The Comprehensive Minimum Data Set (a resident assessment tool) dated 01/20/2026 documented severely impaired cognition with wandering behaviors, rejection of care, and dependence on staff for most activities of daily living, including transfers and standing. A nursing progress note dated 02/02/2026 documented that Resident #164 was transferred to the hospital following reports of shortness of breath and chest pain radiating to the left side. A hospital progress note dated 02/03/2026 documented evaluation for left upper quadrant (upper left part of the abdomen) pain, with imaging revealing minimally displaced fractures (a type of broken bone where the two ends of the bone have cracked or broken, but they have only moved a very small amount from their normal position) of the ninth and tenth ribs. The resident was unable to provide a history of events. The facility's Summary of Investigation dated 02/17/2026, completed by the Director of Nursing, documented that the facility was notified by the hospital on [DATE] that Resident #164 had been diagnosed with minimally displaced ninth and tenth left rib fractures. The investigative summary documented that staff interviews were conducted and that no known or reported incident of fall or trauma was identified. There was no documented evidence in the Summary of Investigation of statements from staff reportedly interviewed or a documented conclusion as to whether the injury was a result of abuse, neglect, or was of unknown origin. During an interview on 06/25/2026 at 4:11 PM, the Director of Nursing stated they were responsible for completing this investigation and they received a hospital report on 02/10/2026 stating that (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #164 was diagnosed with rib fractures. The Director of Nursing stated staff interviews were conducted with employees working all shifts on the day of and prior to Resident #164's hospital transfer and that no incident or trauma was identified. The Director of Nursing stated that staff written statements could not be located and may have been misplaced and that they could not recall why the investigation lacked a determination of whether abuse or neglect had occurred. 2. Resident #32 had diagnoses including Parkinson's disease (a condition where parts of the brain slowly stop working properly, causing movement and other body functions to become harder over time), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and osteoarthritis (a condition where the cartilage in your joints wears down). The Annual Minimum Data Set, dated [DATE] documented moderate cognitive impairment and no history of physical behavioral symptoms toward others. Resident #132 had diagnoses including Alzheimer's disease, cataract (clouding of the lens inside the eye) and schizophrenia (a serious mental health condition that affects how people think, feel and behave). The Quarterly Minimum Data Set, dated [DATE] documented moderately severe cognitive impairment and no behavioral symptoms toward others. The Resident Occurrence Forms dated 04/23/2026 documented that at 7:23 PM, Residents #32 and #132 were observed hitting each other. Resident #32 sustained a superficial scratch to the left hand, and Resident #132 sustained a superficial scratch to the left upper chest. Both residents were evaluated and transferred to the hospital. There was no documented evidence in the facility's investigation of statements from all staff working in the unit who may have potentially witnessed the incident. In addition, there was no documented evidence that available video surveillance was reviewed as part of the investigation. During an interview on 06/26/2026 at 8:30 AM, Certified Nursing Assistant #4 stated they were notified of the incident by other staff who heard a noise. They stated they intervened after being alerted and separated the residents, but could not identify the staff members who initially observed the incident. During an interview on 06/25/2026 at 3:48 PM, Registered Nurse #7 stated they did not fully witness the altercation and responded after hearing a noise, at which time they intervened. During an interview on 06/26/2026 at 12:38 PM, the Director of Nursing Services stated the facility's investigative process requires obtaining statements from all staff on the unit. The Director of Nursing Services acknowledged that additional employee statements could not be located and could not confirm whether they were completed or obtained verbally. The Director of Nursing Services further stated video surveillance was not reviewed because Registered Nurse #7 was believed to be a direct witness. 10 New York Codes, Rules and Regulations 415.4(b)(3)