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	12/22/2023

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45349 Based on record review and interview during the recertification survey of 12/18/23 - 12/22/23, the facility failed to ensure that individual financial records were made available to the resident and/or their representative through quarterly statements and upon request. This was evident for 2 (Resident #72 and #131) out of 35 residents reviewed for Personal Funds. Specifically, there was no documented evidence that quarterly statements were provided to Residents #72 and #131 and/or their representatives. The findings are: A facility policy and procedure titled Resident Banking and Personal Funds reviewed / revised on 9/2023, documented individual financial records will be available to the resident or their designated representative within request. The facility will provide quarterly to the resident or their designated representative a copy of the resident banking records / funds. 1. Resident #131 had diagnoses of Anxiety Disorder, Depression, Renal Insufficiency, and Schizophrenia. The quarterly Minimum Data Set (MDS) dated [DATE] documented Resident #131 participated in the assessment and was cognitively intact. A Personal Needs Account (PNA) Ledger documented Resident #131 had a balance of $55.10 on 3/31/23, a balance of $0.18 on 6/30/23, and a balance of $0.34 on 9/30/23. There was no documented evidence that Resident #131 and/or their representative had been provided with quarterly statements. 2. Resident #72 had diagnoses of Bipolar Depression, Schizophrenia, and Diabetes Mellitus. The quarterly MDS dated [DATE] documented Resident #72 was cognitively intact. A Personal Needs Account (PNA) Ledger documented Resident #72 had a balance of $5,884.20 on 3/31/23; a balance of $5,761.41 on 6/30/23, and a balance of $5,614.96 on 9/30/23. There was no documented evidence that Resident #72 and/or their representative had been provided with quarterly statements. An interview was conducted with Resident #131 on 12/19/23 at 12:04 pm, they stated they have not received any financial statements and that they want to receive such statements. (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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Human Resources / Payroll Manager on 12/22/23 at 10:16 am, they stated that bank statements are done by the Account Receivables Department. The Account Receivables Department gives the statements to the Director of Social Work who either mail or gives the statement to the residents. The Human Resources / Payroll Manager stated they do not know how often the statements are provided to the residents. An interview was conducted with the Director of Social Work on 12/22/23 at 10:24 am, they stated that residents were provided bank statements quarterly. They give it to the residents who has capacity or otherwise mail the statements to the designated representative. The Director of Social Work stated they do not ask residents to sign or get proof of mailing. An interview was conducted with the Administrator on 12/22/23 at 1:25pm, they stated that quarterly statements were given either to the resident and/or their representative depending on their cognitive status. 10 NYCRR 415.26(h)(5)(i)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864 Based on observation, record review, and interviews conducted during the Recertification Survey from 12/18/23 through 12/22/23, the facility failed to ensure that the services provided by the facility met professional standards of quality. This was evident in 1 (Resident #205) of 3 residents reviewed for care planning. Specifically, Resident #205 was observed on two occasions with a Peripherally Inserted Central Catheter (PICC) to their right arm. There was no documentation in the resident's chart about the presence of a PICC. There was no documented evidence that Resident #205's PICC dressing was changed or that the site was monitored for infection. The findings are: An undated policy titled PICC Line documented that PICC is used for medium to long term intravenous access. The policy stated the routine care and maintenance of a PICC involves weekly flushing and dressing. However, if the PICC is used for the administration of drugs or fluids, the PICC must be flushed immediately post completion of the infusion. Security devices such as stat lock / grip lock requires changing once every 4 weeks. Resident #205 was admitted to the facility on [DATE] with diagnoses of Diabetes Mellitus (DM), Osteomyelitis Bilateral Feet, and Diabetic Foot Ulcer. The Minimum Data Set (MDS) dated [DATE] documented Resident #205's cognition was intact. The MDS documented Resident #1 was taking antibiotic. The MDS did not document the presence of central intravenous (IV) access. On 12/19/23 at 11:44 AM and 12/20/23 at 12:00 PM, Resident #205 was observed with a PICC to their right arm. [NAME] bandage was observed wrapped loosely around the PICC. A Hospital Patient Review Instrument (PRI) dated 10/24/23 documented Resident #205 was on IV antibiotic, PICC line on right basilic was placed on 10/17/23. A Comprehensive Care Plan (CCP) for antibiotic therapy related to long term use of antibiotics was initiated for Resident #205 on 10/27/23. The CCP did not indicate the name and route of administration for the antibiotic. The Physician's Order dated 10/24/23 documented IV Cefazolin 2 grams in 100 milliliters normal saline (NS) by intravenous route every 8 hours for 25 days. The physician's order did not document the type of intravenous access. A review of Physician's Orders with a last review date of 12/17/23 did not reveal orders for PICC dressing change, PICC flush, or to monitor for infection. There was no documented evidence that Resident #205's PICC was assessed. There was no documented evidence that PICC dressing changes were made, and that site was monitored for infection. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurses' Notes dated 10/24/23 8:36 PM documented Resident #205 was a new admission. Resident #205 was alert and oriented to person, place, and time and had a wound vacuum assisted closure (VAC). The notes did not document the presence of PICC line. A Physician's Admission Notes dated 10/27/2023 6:32 AM documented Resident #205 was admitted for skilled nursing facility placement for long term antibiotic use for osteomyelitis and wound VAC changes. Physical examination documented wound VAC in place. The physician admission notes did not document the presence of PICC line. A Nurses' Notes dated 12/21/23 at 2:16 PM documented Resident #205's PICC line was discontinued and removed by the Nurse Practitioner. A Nurse Practitioner's Notes dated 12/21/23 at 2:17 PM documented Resident's right arm PICC line was removed due to completion of antibiotic. On 12/21/23 at 11:36 AM, Resident #205 was observed lying in bed. Resident #205 stated that their PICC was removed yesterday, 12/20/23. On 12/21/23 at 01:49 PM, the Assistant Director of Nursing was interviewed and stated that they were not aware that Resident #205 had a PICC line. The Assistant Director of Nursing stated they completed Resident #205's admission assessment on 10/24/23 but could not recall if Resident had a PICC. On 12/22/23 at 11:56 AM, Licensed Practical Nurse #1 was interviewed and stated they were the charge nurse on the unit. They stated that Resident #205 was on IV antibiotic and had a PICC. Licensed Practical Nurse #1 stated that as the nurse on the unit, they must ensure that the line was not clogged and was not infiltrated. They stated they must ensure there were orders to check the PICC and would document it in the 24-hour report and nurses' notes. Licensed Practical Nurse #1 stated they did not document about the PICC. They stated that the Nurse Practitioner was notified via the communication book that Resident #205's PICC had to be removed. On 12/22/23 at 02:36 PM, Nurse Practitioner #1 was interviewed and stated that the Medical Doctor would do the initial assessment and would document if there was any intravenous access. They stated that Registered Nurses are responsible for putting in orders for PICC. Nurse Practitioner #1 stated they removed Resident #205's PICC after a request was written in the communication book On 12/22/23 at 02:49 PM, the Director of Nursing was interviewed and stated facility had protocol for PICC line. They stated there must be an order for flushing the PICC, dressing change, and monitoring the site. The Director of Nursing stated they did not know why Resident #205 did not have these orders for PICC. 10 NYCRR 415.11(c)(3)(i)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on record review and interview conducted during a Recertification Survey completed from 12/18/23 through 12/22/23, the facility failed to maintain clinical records in accordance with accepted professional standards and practices, that are complete and accurately documented. This was evident for 1 (Resident #112) of 1 resident reviewed for Insulin out of 35 sampled residents. Specifically, Resident #112 with a diagnosis of Diabetes Mellitus, had a physician's order dated 11/06/23 documented Fingerstick (a blood test for which blood is obtained by a finger stick) two times a day; Notify Physician / Nurse Practitioner when blood sugar level results are less than 70 or greater than 300. Review of Resident #112's medical records revealed that the fingerstick blood sugar level results were not documented. The finding is: The facility policy titled Diabetes Mellitus Guidelines last reviewed on 03/28/18 documented that the nursing staff shall monitor and document the blood glucose (blood sugar) according to the physician orders. Resident #112 was admitted to the facility with diagnoses of Diabetes Mellitus, Schizophrenia, and Mild Persistent Asthma. The most recent MDS assessment dated [DATE] documented that Resident #112's cognitive status was severely impaired. A Comprehensive Care Plan (CCP) on Diabetes Mellitus was initiated on 07/16/23 with last evaluation note dated 10/03/23. The facility interventions included monitor for signs/symptoms of hyperglycemia (increased blood sugar) and hypoglycemia (decreased blood sugar), to administer medications per Medical Doctor (MD) orders, and to monitor blood glucose finger stick per MD orders. A physician's order dated 11/06/23 documented Fingerstick two times a day. Notify Physician / Nurse Practitioner when blood sugar level results are less than 70 or greater than 300. The electronic Medication Administration Record (eMAR) from 11/06/23 through 12/19/23 documented that fingerstick was completed twice daily. However, there was no documentation of blood sugar results on the eMAR. Review of Resident #112's medical records revealed that the last blood sugar recorded was on 10/16/23 4:44 pm at 85 milligrams / deciliter. There was no blood sugar result documented after 10/16/23. On 12/21/23 at 10:47 AM, an interview was conducted with License Practical Nurse #2. They stated that they check Resident #112's blood sugar level before they administer insulin. License Practical Nurse #2 stated they realized there was nowhere to document the blood sugar level on the eMAR. They stated that there was a similar situation before, and they discovered that the error was from the electronic medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/21/23 03:55 PM, an interview was conducted with the Assistant Director of Nursing. They stated that Resident #112's blood sugar level was being monitored but there was nowhere to document the results on the eMAR. They concluded that it was an error from the electronic medical record. On 12/22/23 at 01:11 PM, an interview was conducted with the Director of Nursing. They stated that they were not aware that the nursing staff were not documenting Resident #112's blood sugar results. The DON stated the error started when the fingerstick order was entered but documentation for the result was not added. On 12/21/23 at 10:38 AM, an interview was conducted with the [NAME] President of Clinical Operations. They stated they reviewed Resident #112's medical record and found that nurses were doing the fingerstick. However, the electronic medical record (EMR) was not set to allow nurses to document the blood sugar results. They stated that whoever entered the order did not check the part of the order to enable nurses to enter the blood sugar level. 10 NYCRR 415.22(a)(1-4)