

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 06/12/2024
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 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876</p> <p>Based on observation, interviews, and record review conducted during the Recertification Survey from 06/03/2024 to 06/11/2024, the facility did not ensure that a resident received foot care and treatment in accordance with professional standards of practice. This was evident for 1 (Resident #191) of 4 residents reviewed for pressure ulcer/injury. Specifically, Resident #191 did not receive the recommended wound treatment made by the Infectious Disease consultant and podiatrist for the care and treatment of diabetic foot ulcer.</p> <p>The findings are:</p> <p>The facility policy titled Foot Care, with an effective date of 06/2023, documented that residents receive appropriate care and treatment to maintain mobility and foot health. Residents are provided foot care and treatment in accordance with professional standards of practice. Overall foot care includes the care and treatment of medical conditions to prevent foot complications from these conditions (Diabetes, Peripheral Vascular disease, and immobility, etc.).</p> <p>The facility policy titled Diabetic Foot Ulcer with an effective date of 06/2023 documented that the ulcer should be kept clean and bandaged and cleansed daily with a wound dressing or bandage. Response to treatment should be evaluated regularly.</p> <p>Resident #191 had diagnoses of Diabetes Mellitus with Foot Ulcer and Peripheral Vascular Disease (a disorder of the blood vessels outside the heart).</p> <p>The Minimum Data Set assessment dated [DATE] documented Resident #191 had intact cognition. The assessment documented that the Resident had diabetic foot ulcers. The resident required set-up or clean-up assistance for putting on/taking off footwear and had not rejected evaluation or care.</p> <p>On 06/05/2024 at 9:17 AM, Resident # 191 was observed in their room with a yellow-stained and soiled gauze dressing wrapped around their left foot.</p> <p>A nursing progress note dated 04/23/2024 documented that Resident #191 was seen for referral to a podiatry consult on 04/16/2024. Resident # 191 stated they had a lateral (the side of the body or part of the body that is away from the middle) left foot wound.</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
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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Infectious Disease Consultation Form dated 05/08/2024 documented on the findings that on the left foot lateral side, the gauze was stained after skin debridement 2 weeks ago. Recommendations were to observe the site keep clean and dry, and a topical antibiotic ointment was prescribed.</p> <p>A nursing progress note by Registered Nurse #2 dated 05/08/2024 documented Resident #191 returned from the Infectious Disease revisit with a recommendation for a topical antibiotic ointment to the debrided site.</p> <p>A nursing progress note by Registered Nurse #2 dated 05/15/2024 at 9:22 AM documented Resident #191 returned from Podiatry appointment for toenail removal. The podiatry findings documented an ulcer to the left foot, lateral aspect closed with no sign of infection. The podiatrist recommended hydrogel (a wound dressing that promotes healing, provides moisture, and offers pain relief with cool, high water content) to the wound and dry sterile dressing.</p> <p>A review of Resident #191's comprehensive care plan revealed no documented care plan and no appropriate interventions to adequately address the wound on the lateral aspect of the left foot.</p> <p>A review of the physician's orders from 04/01/2024 through 05/31/2024 revealed no treatment orders for Resident #191's wound on the lateral aspect of the left foot.</p> <p>A Wound Consultation Note dated 06/10/2024 at 6:35 AM documented Resident #191 was noted with a diabetic foot ulcer on the left lateral 5th metatarsal (bone in the foot) that measured 0.5 x 0.5 x less than 0.2 centimeters with a scant amount of serous drainage (a clear to yellow fluid that leaks out of a wound) and no odor. The recommended treatments were to apply a fine mesh gauze occlusive dressing for use on low exuding wounds, gauze, dry protective dressing with wrap dressing every Monday, Wednesday, and Friday.</p> <p>On 06/05/2024 at 9:17 AM, Resident #191 was interviewed and stated they went to a clinic appointment 2 weeks ago because the left side of their left foot was open and bleeding. They stated the doctor placed the gauze on their foot and had been there since. Resident #191 stated they gave their paperwork to the nurses when they came back from the appointment, and no one had checked their foot since they came back from the appointment.</p> <p>On 06/06/2024 at 10:37 AM, the Clinic Coordinator was interviewed and stated they gave Resident #191's Infectious Disease consultation report to Registered Nurse #2 when the Resident came back from their appointment on 05/08/2024.</p> <p>On 06/06/2024 at 11:41 AM, Registered Nurse #2, who was the Registered Nurse supervisor, was interviewed and stated they documented in the progress note on 05/08/2024 the infectious disease consult recommendations for the assessment and treatment of the left lateral foot wound for Resident #191. Registered Nurse #2 stated they did not document the recommended treatment orders in the physician's order and did not notify the attending physician of the recommendations because the attending physician receives the consultation report from the clinic coordinator.</p> <p>On 06/04/2024 at 9:24 AM, Licensed Practical Nurse #4 was interviewed and stated they were not aware of Resident #191's left lateral foot wound. They stated they would only be made aware of a wound if an order was written, if a wound consult was triggered by an assessment, or if they were notified by the nursing staff from the morning report.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/06/2024 at 11:08 AM, Nurse Practitioner #2 was interviewed and stated Registered Nurse #2 had not notified them of the consultation treatment orders for Resident #191. They stated that if they had been notified, they could have entered the treatment orders and it could have been carried out in the treatment administration record.</p> <p>On 06/06/24 at 10:48 AM, The Director of Nursing was interviewed and stated the Nursing Supervisor was responsible for notifying the attending physician of consult recommendations and for transcribing the recommended wound treatment order.</p> <p>On 06/07/24 at 08:55 AM, The Medical Director was interviewed and stated that the medical provider or the attending physician was responsible for following up on the consultation recommendations.</p> <p>415.12(k)(7)</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876</p> <p>Based on interview and record review conducted during the Recertification Survey from 06/03/2024 to 06/11/2024, the facility failed to ensure that the physician reviewed the resident's total program of care. This was evident for 1 (Resident #191) of 4 residents reviewed for pressure ulcer/injury. Specifically, there was no documented evidence the treatment recommendations from the Infectious Disease consultant and podiatrist for Resident #191's diabetic ulcer on the left foot were reviewed by the attending physician. Additionally, there was no documented evidence that Resident #191's diabetic ulcer on the left foot was evaluated by the attending physician and/or the nurse practitioner.</p> <p>The findings are:</p> <p>The facility policy titled Physician Visits and Physician Delegation, last reviewed on 01/2024 documented it is the policy of the facility to ensure the physician takes an active role in supervising the care of residents. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs.</p> <p>The facility's policy titled Consulting Physician/Practitioner Orders with a revised date of 01/2024 documented that the attending physician shall authenticate orders for the care and treatment of assigned residents. A consulting physician/practitioner's orders are those orders provided to the facility by a physician/practitioner other than the resident's attending physician who was acting on behalf of the attending physician.</p> <p>Resident #191 had diagnoses of Diabetes Mellitus with Foot Ulcer and Peripheral Vascular Disease (a disorder of the blood vessels outside the heart).</p> <p>The Minimum Data Set assessment dated [DATE] documented Resident #191 had intact cognition. The assessment documented that the Resident had diabetic foot ulcers. The resident required set-up or clean-up assistance for putting on/taking off footwear and had not rejected evaluation or care.</p> <p>A nursing progress note dated 04/23/2024 documented Resident #191 was seen for referral to a podiatry consult on 04/16/2024. Resident # 191 stated they had a wound on the left lateral foot (outer edge of the foot).</p> <p>A review of the physician and nurse practitioner progress notes from 04/23/2024 through 05/31/2024 did not reveal documented evidence that Resident #191's wound on the left lateral foot was evaluated by the nurse practitioner or the attending physician.</p> <p>An Infectious Disease Consultation Form dated 05/08/2024 documented the findings that on the left foot lateral side, the gauze was stained after skin debridement 2 weeks ago. Recommendations were to observe the site, keep clean and dry, and apply a topical antibiotic ointment.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing progress note by Registered Nurse #2 dated 05/15/2024 at 9:22 AM documented Resident #191 returned from Podiatry appointment for toenail removal. The podiatry findings documented an ulcer to the left foot, lateral aspect closed with no sign of infection. The podiatrist recommended hydrogel (a wound dressing that promotes healing, provides moisture, and offers pain relief with their cool, high-water content) to the wound and dry sterile dressing.</p> <p>A review of the physician and nurse practitioner progress notes from 05/08/2024 through 06/05/2024 did not reveal documented evidence the consultation form with treatment recommendations made by the Infectious Disease consultant, and podiatrist were reviewed by the nurse practitioner or the attending physician.</p> <p>A review of the physician's orders from 04/01/2024 through 05/31/2024 revealed no treatment orders for Resident #191's wound on the left lateral foot.</p> <p>The Medication and Treatment Administration Records from 04/01/2024 through 05/31/2024 revealed no treatments were administered for Resident #191's wound on the left lateral foot.</p> <p>A Wound Consultation Note dated 06/10/2024 at 6:35 AM documented Resident #191 was noted with a diabetic foot ulcer on the left lateral 5th metatarsal that measured 0.5 x 0.5 x less than 0.2 centimeters with a scant amount of serous drainage (a clear to yellow fluid that leaks out of a wound) and no odor. The recommended treatments were to apply a fine mesh gauze occlusive dressing for use on low exudating wounds, gauze, dry protective dressing with wrap dressing every Monday, Wednesday, and Friday.</p> <p>On 06/06/2024 at 11:08 AM, Nurse Practitioner #2 was interviewed and stated Registered Nurse Supervisors were supposed to let them know when they received the consultation recommendations. Nurse Practitioner #2 stated Registered Nurse #2 had not notified them of the consultation treatment orders for Resident #191. They stated that if they had been notified, they could have entered the treatment orders and it could have been carried out in the treatment administration record.</p> <p>On 06/07/2024 at 8:55 PM, the Attending Physician for Resident #191, who was also the Medical Director, was interviewed and stated the attending physician or the nurse practitioner gives the consult orders, and they were responsible for following up on the consultation recommendations.</p> <p>415.15(b)(2)(iii)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876</p> <p>Based on interview and record review conducted during the Recertification Survey from 06/03/2024 through 06/11/2024, the facility did not ensure sufficient nursing staff were available to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility's staffing levels were repeatedly below facility-assessed minimum levels.</p> <p>The findings include but are not limited to:</p> <p>The facility policy titled Staffing Procedure dated 08/2023 documented that it was important to reach the desired par levels that the Administration and Nursing had set.</p> <p>The Facility assessment dated ,d+[DATE] documented a facility capacity of 240 residents with an average daily census of 206. The facility assessment documented based on the resident population and their needs for care and support, the total number of required staff needed to appropriately meet the needs of the residents at any given time were 35 licensed nurses providing direct care, 76 nurse aides, and 17 other nursing personnel with administrative duties. The facility's general staffing plan documented 1 full-time Director of Nursing, 1 full-time Assistant Director of Nursing, 2 to 3 Registered Nurses for the day shift, 1 Registered Nurse for the evening shift and 1 for the night shift, 1 Licensed Practical Nurse for each unit (5 units), 4 Certified Nursing Assistants for each unit for the day and evening shift for each unit, and 3 Certified Nursing Assistants for each unit for the night shift.</p> <p>A review of the actual staffing schedule for April 2024, May 2024, and June 2024 showed consistently low weekend staffing, with a documented shortage of licensed nurses and nurse aides.</p> <p>The actual staffing schedule documented the following:</p> <p>On 06/09/2024, the staffing schedule showed there was a shortage of nurse aides. There were 15 Certified Nursing Assistants scheduled on the day shift (par level of 20), 16 on the evening shift (par level of 20), and 12 for the night shift (par level of 15).</p> <p>On 06/08/2024, the staffing schedule showed a shortage of Licensed Practical Nurses and nurse aides. There were 4 Licensed Practical Nurses scheduled on the day shift (par level of 5) and 4 on the night shift (par level of 5). There were 16 Certified Nursing Assistants in the evening shift and 10 for the night shift.</p> <p>On 06/02/2024, the staffing schedule showed a shortage of Licensed Practical Nurses and nurse aides. There were 4 Licensed Practical Nurses on the evening shift (par level of 5) and 4 on the night shift (par level of 5). There were 14 Certified Nursing Assistants on the day shift, 15 on the evening shift, and 14 on the night shift.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 05/26/2024, the staffing schedule showed there was a shortage of nurse aides. There were 10 Certified Nursing assistants on the day shift (par level of 20), 12 on the evening shift (par level of 20), and 11 on the night shift (par level of 15).</p> <p>On 05/18/2024, the staffing schedule showed a shortage of nurse aides and Licensed Practical Nurses. There were 1 Licensed Practical Nurse on the day shift (par level of 5), 3 on the evening shift (par level of 5), and 1 on the night shift (par level of 5). There were 15 Certified Nursing Assistants on the evening shift (par level of 20) and 9 for the night shift (par level of 20).</p> <p>On 05/05/2024, the staffing schedule showed a shortage of nurse aides and Licensed Practical Nurses. There were 4 Licensed Practical Nurses on the day shift (par level of 5), 2 on the evening shift (par level of 5), and 4 on the night shift (par level of 5). There were 14 Certified Nursing Assistants on the evening shift (par level of 20).</p> <p>On 05/04/2024, the staffing schedule showed a shortage of Licensed Practical Nurses. There were 2 Licensed Practical Nurses scheduled for the evening shift (par level of 5) and 2 on the night shift (par level of 5).</p> <p>On 06/10/2024 at 9:37 AM, the Staffing Coordinator was interviewed and stated there was a shortage of nursing staff due to call-ins from Certified Nursing Assistants and Licensed Practical Nurses. They stated that, at times, the Registered Nurse Supervisor was doing the job of the Licensed Practical Nurses due to the shortage.</p> <p>On 06/11/2024 at 2:43 PM, Registered Nurse #5 was interviewed and stated the staffing at the facility needs to improve. They stated there were times when there was 1 Registered Nurse in the building for the entire weekend, there was 1 Licensed Practical Nurse to cover 2 to 3 floors for the 7:00 AM - 3:00 PM shift. Registered Nurse #5 stated that the 4th floor did not have a regular licensed practical nurse in 5 months, and the night shift nurse covered the morning shift.</p> <p>On 06/11/2024 at 2:53 PM, Certified Nursing Assistant #10 was interviewed and stated there was a time when they were the only nurse aide on the floor, and a resident helped them out by asking other residents to get their own breakfast tray.</p> <p>On 06/11/2024 at 2:55 PM, Certified Nursing Assistant #11 was interviewed and stated on the days when there was low staffing, residents did not receive timely incontinence care, and not every resident who was scheduled will receive their shower. They stated they prioritize the residents who need the most help.</p> <p>On 06/11/2024 at 3:00 PM, Resident #56 was interviewed and stated there were not enough nurse aides on weekends, and they waited longer to get their medication because the nurse arrived 2 to 3 hours late. Resident #156 stated there were times when there was only 1 nurse aide and no nurse in the unit. They stated they stayed in bed most of the time because there was not enough staff to transfer them out of bed using a mechanical lift. They stated there would be times when there was no nurse on the unit, and the nursing supervisor will arrive at around 10:30 AM to give all residents their medication. Resident #156 stated they complained to the Administrator about not having enough staff, and they were told they were working on it.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 06/11/2024 at 3:43 PM, the Assistant Administrator was interviewed and stated they also work as the Assistant Director of Nursing. The Assistant Administrator stated they make necessary adjustments to staffing when there are not enough nurses and nurse aides. They stated they did not know how the adjustments were made but it was on the staffing policy and procedure.</p> <p>An interview was attempted with the Director of Nursing. The Director of Nursing provided a copy of the staffing procedure and told the Surveyor to read it.</p> <p>10 NYCRR 415.13(a)(1)(i-iii)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>48876</p> <p>Based on interviews and record review conducted during the Recertification Survey from 06/03/2024 to 06/11/2024, the facility did not ensure that the nurse staffing information was posted on a daily basis. This was evident during review of the Staffing Task. Specifically, there were no available postings of nurse staffing information on the weekends for the month of January 2024 through May 2024.</p> <p>The findings are:</p> <p>The facility policy titled Staffing Procedure with the effective date of 08/2023 documented the staffing coordinator was responsible for posting the daily schedule. The policy did not include posting of nurse staffing data.</p> <p>A review of the posted daily nurse staffing information revealed there were no daily nurse staffing data postings available for Saturdays and Sundays from 01/01/2024 through 06/02/2024.</p> <p>During an interview on 06/11/2024 at 12:10 PM, the Staffing Coordinator stated the Registered Nurse Supervisor was responsible for posting the daily nurse staffing on weekends.</p> <p>During an interview on 06/11/2024 at 3:38 PM, Registered Nurse #4, who was the nursing supervisor on weekends, stated they were not given the responsibility to post the daily nurse staffing on weekends.</p> <p>During an interview on 06/10/2024 at 2:48 PM, the Director of Nursing stated the nurse staffing information must be posted daily and the Registered Nurse Supervisors were responsible for weekend posting.</p> <p>During an interview on 06/10/2024 at 2:50 PM, the Administrator stated they moved the posting board where it was noticeable for everybody. The Administrator stated there had been no issue with posting the nurse staffing information and that this was an isolated incident.</p> <p>10 NYCRR 415.13</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48711</p> <p>Based on observation, interview, and record review conducted during the Recertification Survey from 06/03/2024 to 06/11/2024, the facility did not ensure food was prepared in accordance with professional standards for food service safety. This was evident during review of the kitchen facility task. Specifically, kitchen staff were observed not wearing hairnets in the kitchen.</p> <p>The findings are:</p> <p>The facility policy titled Personal Appearance and Conduct issued by Food and Nutrition Services last reviewed on 02/2024 documented all food service personnel will maintain high standards of personal cleanliness and appropriate behavior. All employees must wear hairnets or coverings that cover all of the hair while working.</p> <p>On 06/05/2024 at 10:47 AM, Dietary Worker #1 was observed entering the pot washing station area with no hair covering.</p> <p>On 06/07/2024 at 10:30 AM, Dietary Worker #2 was observed in the main kitchen area with no hair covering.</p> <p>During an interview on 06/05/2024 at 10:47 AM, Dietary Worker #3, who was the Cook, stated everyone entering the kitchen must wear hairnets and beard protectors.</p> <p>During an interview on 06/07/2024 at 10:30 AM, the Food Service Director stated it was mandatory for kitchen staff to wear uniform, hairnets, and beard coverings when in the kitchen.</p> <p>During an interview on 06/10/2024 at 2:48 PM, the Administrator stated the Food Service Director was responsible for ensuring the kitchen staff wear hairnets. They stated kitchen staff received in-service on this policy. The Administrator stated this was a new issue and they had not encountered this issue before.</p> <p>10 NYCRR 415.14 (h)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>48711</p> <p>Based on observations and interviews conducted during the Recertification Survey from 06/03/2024 to 06/11/2024, the facility did not ensure that garbage and refuse were disposed of properly. Specifically, garbage was not properly contained outside of the facility. The dumpster was not covered and there were various types of garbage lying on the ground near and overflowing from the dumpster.</p> <p>The findings are:</p> <p>The facility policy and procedure titled Housekeeping Services with the effective date of 02/2003 documented the facility grounds including building and sidewalks, will be kept free from refuse and litter. The facility will be free from rodents and insects.</p> <p>During an observation on 06/04/2024 at 10:00 AM, there was a large dumpster containing trash in the garbage disposal area. There were trash scattered on the ground around the dumpster area. Lying on the ground, next to the dumpster were 2 broken gray metal food service carts, a packaged terminal air conditioning unit, and wooden pallets that facility use for food delivery pick up and drop off. There were flies observed around the dumpster. There was an uncovered overflowing large green garbage bin containing furniture, laundry containers, and computers. There were clear plastic bags with exposed cans, and 3 cardboard boxes in an uncovered recycling bin.</p> <p>During an observation on 06/05/2024 at 9:56 AM, an uncovered green dumpster was observed in the garbage area overflowing with cardboard boxes. A green uncovered dumpster was observed with trash, flies circling the dumpster, and lying next to the dumpster, on the ground were old tray tables, milk crates, and coffee cups.</p> <p>During an observation on 06/06/2024 at 11:00 AM, an uncovered green dumpster was observed in the garbage area overflowing with cardboards, trash, and old furniture.</p> <p>During an interview on 06/04/2024 at 10:00 AM, the [NAME] stated their responsibility was to maintain the cleanliness of the lobby, the outside perimeter of the facility and the parking lot.</p> <p>During an interview 06/10/2024 at 3:30 PM, The Director of Housekeeping stated garbage is scheduled for pick up on Tuesday, Thursday, and Saturday. They stated there was no need to cover the bins containing trash, furniture, and non-perishables since it was not food trash or perishable items. The Director of Housekeeping stated the kitchen staff were partly responsible for maintaining the garbage bins since they throw food, cans, and trash in the dumpster. They stated the Housekeeping Department was responsible for maintaining the buildings outside perimeter. It had not been determined whose responsibility it was to maintain the area where garbage was disposed of.</p> <p>During an interview on 06/10/2024 at 2:48 PM, the Administrator stated they were not aware of issues with garbage disposal. They stated the dumpster were not supposed to contain perishables. They stated there were 2 bins assigned for kitchen trash and the lids should always be closed. The Administrator stated, the Maintenance Department should have been contacted about garbage refusal issues.</p> <p>10 NYCRR 415.14(h)</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 06/12/2024
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>45344</p> <p>Based on observation, interviews, and record review conducted during the Recertification Survey from 06/03/2024 to 06/11/2024, the facility did not ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. This was evident for 6 of 6 units observed. Specifically, hot water for bathing, hand washing, and personal hygiene was not consistently provided.</p> <p>The findings are:</p> <p>The facility's policy on loss of hot water was not provided by the facility during the Survey.</p> <p>A review of the Maintenance Logbook located on the nurse's station on each unit revealed 6 entries of lack of hot water supply from 04/16/2024 through 06/04/2024.</p> <p>During an observation on 06/05/2024 a resident on the 2nd Floor stated there had been no hot water on the unit for a few months and they reported it to the nurse aides, the water temperature should be 110 degrees Fahrenheit. At approximately 2:00 PM, the water temperature in the 2nd Floor shower room was 70 degrees Fahrenheit. The 4th and 5th Floor shower rooms had no water flow when tested. The Maintenance Director stated the plumbers had been working on the boiler since 06/03/2024.</p> <p>During observation on 06/06/2024 at approximately 9:45 AM, the water temperature in the shower room on the 6th Floor was 54 degrees Fahrenheit, and the water pressure was a trickle.</p> <p>During an observation on 06/06/2024 from 7:30 PM to 8:30 PM, the 5th and 6th Floor shower rooms had no water pressure. The water temperature on the 2nd Floor through the 6th Floor ranged from 69 to 74 degrees Fahrenheit. A resident on the 3rd Floor stated that they had been without hot water for months.</p> <p>On 06/05/2024 at approximately 2:30 PM, during the Resident Council Meeting, Resident #156 stated there had been no hot water in the sink for a week and they had been washed with cold water. Resident #44 stated they had been showered with cold water on 06/04/2024. Residents #18, #79, #37, and #44 stated they all had been washed with cold water.</p> <p>During an interview on 06/07/2024 at 2:00 PM, the Director of Nursing stated wipes had been provided to the residents and extra wipes had been provided to the units when there was loss of hot water supply.</p> <p>During an interview on 06/06/2024 at 11:00 AM, the Administrator stated residents have not complained about the lack of hot water. They stated there had been a previous incident when there was a lack of hot water supply in the facility, and it had been fixed. The lack of hot water supply re-occurred this week and boiler parts were being replaced.</p> <p>10 NYCRR 415.29(f)(1-7)</p>		