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	11/21/2024

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45351 Based on record review and interviews conducted during the Recertification and Complaint (NY00351064) Survey from 11/13/2024 to 11/21/2024, the facility did not ensure that it promoted and facilitated a resident's right to self-determination through support of resident's choice. This was evident for 1 (Resident #48) of 7 residents reviewed for Activities of Daily Living. Specifically, Resident #48's bathing preference was not honored. The findings are: The facility's policy titled Nursing Home Resident Rights with a reviewed date of 06/2022 documented the resident has a right to choose activities, schedules, health care and providers of health care services consistent with their interests, assessments, and plan of care. The facility's policy titled Activities of Daily Living with a reviewed date of 05/2023 documented the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in activities of daily living do not deteriorate unless unavoidable. The policy documented a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene. Resident #48 was admitted to the facility with diagnoses of Cerebral Palsy (a group of conditions that affect movement and posture caused by damage that occurs to the developing brain, most often before birth) and Depression. The annual Minimum Data Set assessment (a resident assessment and care screening tool) dated 08/30/2024 documented Resident #48 was cognitively intact, required substantial/maximal assistance for showering or bathing, and had not rejected care. The assessment also documented that it was somewhat important for Resident #48 to choose between a tub bath, shower, bed bath, or sponge bath. On 11/15/2024 at 10:00 AM, Resident #48 was interviewed and stated there was not enough staff to take care of them, especially on the weekends. They stated they usually wait for 2 to 4 hours for staff to respond to their call for help because there is only one certified nursing assistant working on the floor. Resident #48 further stated they were not getting their showers. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive care plan for self-care deficit was initiated for Resident #48 on 08/24/2023 and was last reviewed on 08/31/2024. The care plan documented Resident #48 required extensive assist of 1 staff for bathing/showers. The facility interventions included providing needed assistance during activities of daily living care. The care plan did not document Resident #48's bathing preferences. The Resident Nursing Instructions (a report containing resident care instructions that Certified Nursing Assistant must provide) with a revision date of 09/10/2024 documented Resident #48's bathing type was shower, and the bathing schedule was Mondays and Thursdays during the 7:00 AM to 3:00 PM shift. The Certified Nursing Assistant Accountability Record for bathing from 10/01/2024 to 11/15/2024 had no documented evidence Resident #48 received showers. The record documented Resident #48 received a bed bath on 10/21/2024, 10/31/2024, and 11/07/2024 during the 7:00 AM to 3:00 PM shift. On 11/19/2024 at 11:05 AM, Certified Nursing Assistant #10 was interviewed and stated there were instances when Resident #48 refuses to be showered and in this case, a bed bath may be provided, and the unit nurse must be notified. On 11/20/2024 at 10:06 AM, Certified Nursing Assistant #3 was interviewed and stated Resident #48 requires total care in all activities of daily living and has showers scheduled twice a week. They stated Resident #48 was given a bed bath instead of a shower during the 7:00 AM to 3:00 PM shift because Resident #48 did not want to wake up early for the shower. Certified Nursing Assistant #3 stated they do not recall offering Resident #48 a shower at a later time. On 11/20/2024 at 10:17 AM, Certified Nursing Assistant #11 was interviewed and stated Resident #48 wanted their shower during the evening shift. They stated it has been a while since they had given Resident #48 a bed bath. Certified Nursing Assistant #11 further stated they were not sure if the nurse knew that Resident #48 wants to have their shower in the evening, or if the Resident's shower schedule had been moved to the evening shift. On 11/19/2024 at 10:45 AM, Licensed Practical Nurse #2 was interviewed and stated they were not aware Resident #48 had been refusing showers during the 7:00 AM to 3:00 PM shift or that Resident #48 would like the schedule changed to a later shift. On 11/21/2024 at 10:27 AM, the Director of Nursing was interviewed and stated the residents' shower schedule is based off the Unit Shower List. They stated the unit shower list shows the shower schedule for each room number, but the schedule may change if the resident or their representative have other preferences. 10 NYCRR 415.5(b)(1-3)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44843 Based on record review and interviews conducted during the Recertification and Complaint (NY00350179) from 11/13/2024 to 11/21/2024, the facility did not ensure that residents were free from abuse, neglect, and exploitation. This was evident in 2 (Resident #118 and #151) of 6 residents reviewed for Abuse. Specifically, Resident #118 who had history of stealing and being involved in physical altercations, was not provided supervision and monitoring despite the staff being aware of Resident #118's behavior. Subsequently, on 08/02/2024, Resident #118 snatched a $20 bill from Resident #151's hand while they were on the elevator. Resident #151 hit Resident #118's head with a cane. Resident #118 sustained head lacerations that required emergency medical intervention. Resident #118 had 14 staples to the wound. This resulted in actual harm to Resident #118 that was not Immediate Jeopardy. Cross Reference: F657 - Care Plan Timing and Revision The findings are: The facility's policy on Abuse Prohibition and Prevention with a reviewed date of 05/2023 documented the intent of the policy was to prevent/prohibit resident abuse. The facility has zero tolerance for abuse and must provide a safer resident environment and protect all residents. The policy defined abuse as the willful infliction of injury. Willful was defined as the individual acting deliberately to inflict injury or harm. The policy documented that abuse can be resident to resident. A Resident Occurrence Form dated 08/02/2024 documented that at 11:15 AM, Resident #118 was hit in the head with a cane by Resident #151 while they were in the basement. Resident #118 stated while getting in the elevator in the basement, a resident who was inside the elevator hit them in the head with a cane and they did not know why. Resident #118 was sent to the emergency roiagnom on [DATE] at 12:15 PM. Computed Tomography (also called a CT scan, is a type of imaging that uses X-ray techniques to create detailed images of the body) of the head was completed at the hospital with no acute findings, and no acute fractures of the facial bones. The Incident/Accident Employee Statement completed by the Registered Nurse Supervisor dated 08/02/2024 documented Resident #151 was interviewed by the nursing supervisor and stated they had an altercation with Resident #118 in the elevator at the basement. Resident #151 stated Resident #118 snatched their money. Resident #118 hit Resident #151 while trying to retrieve their money. Resident #151 stated they retaliated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The undated facility's Summary of Investigation documented that on 08/02/2024 at around 11:15 AM, Resident #118 was involved in an altercation with Resident #151 in the basement elevator. The facility investigation revealed there was cause to believe resident abuse had occurred. The documented Resident #118 insisted to ride the elevator but Resident #151 told Resident #118 that the door would not close. Resident #118 then grabbed the $20 bill from Resident #151's hand. Resident #151 hit Resident #118 with a cane. The incident was witnessed by 3 other residents who were present in the elevator . Resident #118 was sent to the hospital for follow-up care on 08/02/2024 and returned to the facility on [DATE]. Resident #118 sustained injury to the head with 14 staples to their scalp. 1.) Resident #151 was admitted to the facility with diagnoses of Chronic Kidney Disease, Opioid Abuse with withdrawal, and Chronic Obstructive Pulmonary Disease (a term for lung and airway diseases that restrict your breathing). The Minimum Data Set assessment dated [DATE] documented Resident #151 had moderate impairment in cognition and had no behavioral symptoms. A care plan for victimization was initiated for Resident #151 on 05/26/2022. The facility intervention included to redirect as needed. A care plan note by the social worker dated 08/13/2024 documented Resident #151 was reported to be involved in a physical altercation with a peer. Resident #151 stated Resident #118 stole their money. Social Worker provided counseling. There was no documented evidence the interventions on the comprehensive care plan were reviewed or evaluated after the resident-to-resident physical abuse on 08/02/2024. 2.) Resident #118 was admitted to the facility with diagnoses which included Violent Behavior, Unspecified Mood Disorder, and Parkinson's Disease. The quarterly Minimum Data Set assessment (a resident assessment and care tracking tool) dated 08/09/2024 documented Resident #118 had moderate impairment in cognition and required supervision for most activities of daily living. The Minimum Data Set did not document any behavioral symptom. A nurse's note dated 08/02/2024 at 12:52 PM documented Resident #118 was hit in the head by another resident with a cane at around 11:20 AM. Resident #118 had bleeding from the head, 911 was called and was transferred to the emergency room . A nurse's note dated 08/03/2024 at 12:50 PM documented a call was received from the physician at the emergency room who stated Resident #118 had been treated with lacerations to the head and had 14 staples. The physician stated Resident #118 was in police custody while at the emergency room . A nurse's note dated 08/04/2024 at 5:29 PM documented Resident #118 was admitted from the hospital at 4:30 PM. Resident #118 was assessed with 2 lacerations on the head, each measured 5 centimeters in length, with 14 staples. The emergency room after visit summary dated 08/04/2024 documented Resident #118's reason for visit was headache. Computed Tomography images of the brain was completed on 08/03/2024, no intracranial (within the skull) mass or bleeding, lacerations of bilateral frontal scalp, underlying calvarium (top part of skull) was intact. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A medical progress note by Staff Physician #1 dated 08/05/2024 at 6:21 AM documented Resident #118 had mild pain at the wound site of the head injury. Current medications were reviewed with no changes made, to start Tylenol 1000 milligrams as needed every 8 hours. A medical wound consultant note by Nurse Practitioner #1 dated 08/05/2024 at 6:54 AM documented Resident #118 was hit in the head in an altercation. Resident had 2 lacerations on the head, 3 centimeters each, with 14 staples. Apply betadine (a topical antiseptic) and leave open to air. A care plan for victimize/victimization was initiated for Resident #118 on 06/27/2023. The facility interventions included identifying triggers for behavior, room change as appropriate, and close observation on every half hour to check for behavior and safety monitoring. The care plan notes documented on 09/01/2023, Resident #118 was accused by another resident of stealing their wallet. This resulted in Resident #118 being pushed by the other resident and falling to the floor. A care plan for mood and behavior patterns were initiated for Resident #118 on 06/27/2023 and was last reviewed on 08/09/2024. The care plan documented Resident #118 had behavior of taking multiple towels and bed sheets and attempted to snatch a candy from another resident. The facility interventions included monitoring changes in cognition, mood, and behavior and to notify the physician; encourage daily activities, and to encourage socialization with peers. The care plan notes documented Resident #118 had history of non-compliance with care and exposing their private parts while in the day room. A care plan for victimization/aggressive behavior was initiated for Resident #118 on 06/27/2023.The facility interventions included psychiatric evaluation, 1:1 monitoring, and protecting from overstimulation. The care plan notes documented Resident #118 had been involved in an altercation with another resident on 09/15/2023 and 04/21/2024. A care plan note by the social worker dated 08/28/2024 documented Resident #118 had an altercation with a peer on 08/02/2024, social worker will continue to follow up. There was no documented evidence the care plan was updated after the resident to resident physical abuse on 08/02/2024. There was no documented evidence of close observation or every half hour check and no documented evidence of 1:1 monitoring as stated in the 06/27/2023 care plan interventions. On 11/18/2024 at 11:35 AM, Certified Nursing Assistant #3 was interviewed and stated Resident #118 was alert and oriented to person, place, and time and does not follow instructions. Certified Nursing Assistant #3 stated Resident #118 had behavior issues like wandering to other units and stealing things from other residents or staff when no one was inside the room. Certified Nursing Assistant #3 stated they redirect Resident #118 when the Resident was on the unit however, they do not monitor Resident #118 when they leave the unit. On 11/20/2024 at 10:20 AM, Certified Nursing Assistant #9 was interviewed and stated they took something down to the basement on 08/02/2024 and observed Resident #151 and #118 fighting in the elevator. Certified Nursing Assistant #9 stated they tried to stop the residents from fighting and called for help. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 11/20/2024 at 10:29 AM, Licensed Practical Nurse # 2 was interviewed and stated Resident #118 liked to steal things from other residents on their unit and goes to other floors to steal things. Licensed Practical Nurse #2 stated they do not know if Resident #118 is monitored when the resident leaves the unit and goes to other floors. On 11/21/2024 at 03:06 PM, Licensed Practical Nurse #1 was interviewed and stated they would see Resident #118 on their unit (a different unit from Resident #118's unit), but they do not monitor them. On 11/20/2024 at 11:42 AM, Registered Nurse #1 was interviewed and stated they were not sure if the staff on other floors were aware of Resident # 118's behavior or if Resident #118 was monitored when they went to other floors. On 11/20/2024 at 11:48 AM, The Director of Social Services was interviewed and stated Resident #118 often steals and they were aware of the altercation Resident #118 had with Resident #151 on 08/02/2024. They stated their role was to advocate for Resident #118, but it was the nursing department's responsibility to initiate interventions and monitor Resident #118's behavior. On 11/21/2024 at 3:38 PM, the Director of Nursing was interviewed and stated they were aware of Resident #118's behavior issues such as stealing and exposing themselves. The Director of Nursing stated the nurse supervisor is responsible for updating the care plans to manage Resident #118's behavioral issues. The Director of Nursing had no response as to how Resident #118 was monitored and supervised when they leave their unit. 10 NYCRR 415.4(b)(1)(i)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on record review, and interviews conducted during the Recertification survey from 11/13/2024 to 11/21/2024, the facility did not ensure that the assessment accurately reflected the resident's status. This was evident for 3 (Residents #462, #311, and #118) of 38 total sampled residents. Specifically, 1.) Resident #462's discharge status was inaccurately documented in the Minimum Data Set assessment. 2.) Resident #311's diagnosis of Schizophrenia was not documented in the Resident's quarterly Minimum Data Set assessment. 3.) Resident #118's behavior symptoms was inaccurately documented in the Minimum Data Set assessment. The findings are: The facility's policy titled Minimum Data Set with a reviewed date of 06/2024 documented residents are assessed using a standardized and comprehensive process to identify care needs, ensure proper care delivery, and support resident-centered care planning. The facility policy titled Minimum Data Set 3.0 Completion with a reviewed date of 12/09/2021 documented the responsibility of all sections of the Minimum Data Set will be clearly assigned. Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections. 1.) Resident #462 was admitted to the facility with diagnoses of Depression, Hypertension (a medical term for high blood pressure), and Hyperlipidemia (a medical term for abnormally high levels of fats in the blood). The Minimum Data Set assessment (a resident assessment and care screening tool) dated 08/30/2024 documented Resident #462 was discharged on [DATE] to a short-term general hospital. The medical progress notes dated 09/01/2024 at 3:53 PM documented Resident #462 completed physical therapy rehabilitation. Resident #462 no longer needs nursing home facility services and was medically stable and cleared for discharge safely into the community. The nursing progress notes dated 08/30/2024 at 10:02 PM documented Resident #462 was discharged to the community. On 11/20/2024 at 9:20 AM, the Minimum Data Set Coordinator was interviewed and stated Resident #462 was discharged home on 08/30/2024 and this should have been reflected on the Minimum Data Set assessment. The Minimum Data Set Coordinator stated it was an oversight that Resident #462's discharge status was inaccurately reflected in the assessment. 44842 2.) Resident #311 was admitted to the facility with diagnoses of Dementia, Schizophrenia (a serious mental health condition that affects how people think, feel, and behave), and Essential Hypertension (an abnormally high blood pressure that's not the result of a medical condition). (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	The Hospital and Community Patient Review Instrument (a medical evaluation tool that identifies whether an individual is eligible for skilled nursing care placement) dated 06/04/2024 documented Resident #311's primary diagnosis was Schizophrenia. The Psychiatric Evaluation dated 10/09/2024 documented Resident #311's diagnosis as Undifferentiated Schizophrenia (a term used for someone showing symptoms of schizophrenia, such as delusions, hallucinations, or catatonic behavior but without a clear pattern or dominant feature). Resident #311 was on Olanzapine (an antipsychotic medication used to treat schizophrenia). The psychiatrist recommended to continue with current medication as gradual dose reduction is not recommended due to potential relapse and increase in psychiatric symptoms. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #311 was severely cognitively impaired. The assessment documented the Resident's primary diagnosis was Unspecified Dementia. Schizophrenia was not included in the list of active diagnoses. On 11/19/2024 at 4:35 PM, the Minimum Data Set Coordinator was interviewed and stated they completed Resident #311's Minimum Data Set, dated dated dated [DATE] and was responsible for the accuracy of residents' diagnoses in the assessment. They stated they were being careful in coding Schizophrenia in the Minimum Data Set assessment because of the memorandum they received from the Centers for Medicare and Medicaid Services. They stated the new psychiatrist did not diagnose Resident #311 with Schizophrenia, only with Dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities). The Minimum Data Set Coordinator did not specify when Resident #311 was evaluated by the new psychiatrist. 44843 3.) Resident #118 was admitted to the facility with diagnoses which included Violent Behavior, Unspecified Mood Disorder, and Parkinson's Disease (a movement disorder of the nervous system). The quarterly Minimum Data Set assessment (a resident assessment and care tracking tool) dated 08/09/2024 documented Resident #118 had moderate impairment in cognition, required supervision with most activities of daily living. The Minimum Data Set did not document any behavioral symptom. A nurse's note dated 08/02/2024 at 12:52 PM documented Resident #118 was hit in the head by another resident with a cane at around 11:20 AM. The facility's investigation revealed Resident #118 grabbed a $20 bill from Resident #151's hand, which led to a physical altercation between the residents. On 11/19/2024 at 5:23 PM, the Director of Nursing was interviewed and stated the Minimum Data Set Coordinator is responsible for the accuracy of the assessment. 10 NYCRR 415.11(b)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on record review, interviews, and observations conducted during the Recertification and Complaint (NY00350179) Survey from 11/13/2024 to 11/21/2024 the facility did not ensure that comprehensive care plans were reviewed and revised periodically and after each assessment including both the comprehensive and quarterly review assessments. This was evident for 3 (Resident #84, #118, and #151) of 7 residents reviewed for Catheter Care and Abuse out of 38 total sampled residents. Specifically, 1.) Resident #84's care plan for indwelling catheter/external urinary appliance was not reviewed and revised after the Resident returned from an emergency room visit due to urinary retention and pain at the urinary catheter insertion site. Additionally, Resident #84's care plan for indwelling catheter/external urinary appliance was not reviewed and/or revised after each comprehensive and quarterly review assessments. 2.) Resident #118's care plan interventions for behavior and victimization were not reviewed and evaluated after the resident to resident physical abuse on 08/02/2024. 3.) Resident #151's care plan interventions were not reviewed and evaluated following a resident to resident physical altercation on 08/02/2024. This resulted in actual harm to Resident #118 that was not Immediate Jeopardy. Cross Reference: F600 - Free from Abuse and Neglect The findings are: The facility policy and procedure titled Comprehensive Care Plans dated 08/2024 documented it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 1.) Resident #84 was admitted to the facility with diagnoses of Benign Prostatic Hyperplasia with Lower Urinary Tract Symptom (prostate enlargement that includes urinary frequency, urgency, dribbling at the end of urination, and not being able to fully empty the bladder) and Obstructive Uropathy (a condition when urine cannot flow due to obstruction). The annual Minimum Data Set assessment (a resident assessment and care screening tool) dated 08/26/2024 documented Resident #84 was cognitively intact. The assessment documented Resident #84 had an indwelling urinary catheter. Further review of Resident #84's Minimum Data Sets revealed quarterly assessments were completed on 03/04/2024 and 06/04/2024. The quarterly assessments documented Resident #84 had an indwelling urinary catheter. On 11/14/2024 at 10:17 AM, Resident #84 was observed in their room. The Resident was interviewed, and they stated they went to the urology clinic yesterday and had their Foley catheter (a medical device that helps drain urine from your bladder) changed. Resident #84 stated their Foley catheter is changed at the urology office and the drainage bag is changed at the facility weekly. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	A physician's order with an original order date of 11/01/2023 and a renewal date of 11/15/2024 documented general orders for Foley catheter French #16, balloon size, 10 milliliters for Obstructive Uropathy; to change the Foley catheter monthly every 20th of the month and as needed for blockage. An order for urology follow-up for Foley catheter change in 6 weeks was entered on 11/13/2024. A care plan on indwelling catheter/external urinary appliance was initiated for Resident #84 on 11/02/2023. The facility interventions included to observe urine for sediment, cloudy, odor, blood, and amount; to observe for urinary tract infection; to change the catheter as ordered or when blocked, keep drainage bag below suprapubic level and off the floor, and to provide sterile technique when changing catheter. A nurse's progress note dated 10/12/2024 at 9:23 PM documented Resident #84 complained of abdominal pain and stated their Foley catheter was not draining enough and they would like to go to the hospital. Resident #84 was transferred to the hospital for further evaluation. The emergency room provider note dated 10/13/2024 documented Resident #84 presented with chronic indwelling Foley catheter, with complaints of urinary retention for 2 days and pain at the Foley insertion site. The bedside sonogram showed full bladder, resident with acute urinary retention. Urethral catheterization (a standard method of accessing the urinary bladder with the use of a flexible catheter to allow urine to drain) was inserted for relief of acute urinary retention. Resident was discharged from the emergency department on 10/13/2024. A medical progress note dated 10/15/2024 at 3:50 AM documented the date of service was on 10/14/2024. The medical note documented Resident #84 returned from emergency room and was seen for follow up. Resident #84 was stable, the assessment and plan documented were to monitor for any changes, to continue with monitoring of lower urinary symptoms and Foley catheter care every shift, to notify the physician if signs of infection and bleeding were noted. There was no documented evidence Resident #84's comprehensive care plan related to urinary catheter was reviewed and/or revised following the emergency room visit on 10/12/2024 due to urinary retention and pain at the urinary catheter insertion site. There was no documented evidence the same care plan was reviewed and/or revised after the quarterly assessments on 03/04/2024 and 06/04/2024, and after the annual assessment that was completed on 08/26/2024. On 11/20/2024 at 10:26 AM, Registered Nurse #1 was interviewed and stated Registered Nurses on duty are responsible for initiating the comprehensive care plans for newly admitted residents. They stated Registered Nurses are also responsible for reviewing and revising a resident's care plan quarterly and if there is a change in a resident's status. Registered Nurse #1 stated that recently it has been the external consultants the facility hired, who have been updating the residents' care plans. Registered Nurse #1 could not explain why Resident #84's care plan on indwelling catheter was not reviewed. On 11/20/2024 at 4:09 PM, the Director of Nursing was interviewed and stated the nursing supervisors are responsible for initiating the care plans on admission and for updating the care plans quarterly and as needed. The Director of Nursing stated they also assist in updating the residents' care plans. They stated Resident #84's care plan not being reviewed must have been an oversight. 44843 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Manor Nursing & Rehabilitation Center	700 White Plains Road Bronx, NY 10473

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F 0657 Level of Harm - Actual harm Residents Affected - Few	2.) Resident #118 was admitted to the facility with diagnoses which included Violent Behavior, Unspecified Mood Disorder, and Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements). The quarterly Minimum Data Set assessment (a resident assessment and care tracking tool) dated 08/09/2024 documented Resident #118 had moderate impairment in cognition and required supervision for most activities of daily living. The Minimum Data Set did not document any behavioral symptom. A care plan for victimize/victimization was initiated for Resident #118 on 06/27/2023 and was last reviewed on 11/08/2024. The facility interventions include identifying triggers for behavior, room change as appropriate, and close observation on every half hour to check for behavior and safety monitoring. The care plan notes documented that on 09/01/2023, Resident #118 was accused by another resident of stealing their wallet. This resulted in Resident #118 being pushed by the other resident and falling to the floor. A nurse's note dated 08/02/2024 at 12:52 PM documented Resident #118 was hit in the head by another resident with a cane at around 11:20 AM. There was no documented evidence the care plan was updated after the 08/02/2024 incident. A care plan for mood and behavior patterns were initiated for Resident #118 on 06/27/2023 and was last reviewed on 08/09/2024. The care plan documented the Resident had behaviors of taking multiple towels and bed sheets and attempted to snatch a candy from another resident. The facility interventions included monitoring changes in cognition, mood, and behavior and to notify the physician; encourage daily activities, and to encourage socialization with peers. The care plan notes documented Resident #118 had a history of non-compliance with care and exposing their private parts while in the day room. A care plan for victimization/aggressive was initiated for Resident #118 on 06/27/2023 and was last reviewed on 08/29/2024. The facility interventions included psychiatric evaluation, 1:1 monitoring, and protecting from overstimulation. The care plan notes documented Resident #118 had been involved in an altercation with another resident on 09/15/2023 and 04/21/2024. There was no documented evidence the interventions documented on the comprehensive care plan were reviewed and evaluated after resident-to-resident physical abuse on 08/02/2024. There was no documented evidence of close observation, or every half hour checks and no documented evidence of 1:1 monitoring as stated in the care plan interventions. 3.) Resident #151 was admitted to the facility with diagnoses of Chronic Kidney Disease, Opioid Abuse with withdrawal, and Chronic Obstructive Pulmonary Disease (is a term for lung and airway diseases that restrict your breathing). The Minimum Data Set assessment dated [DATE] documented Resident #151 had moderate impairment in cognition and had no behavioral symptoms. A care plan for victimization was initiated for Resident #151 on 05/26/2022 and was last reviewed on 08/13/2024. The facility intervention included to redirect as needed. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	There was no documented evidence the interventions documented on the comprehensive care plan were reviewed and evaluated after resident to resident physical abuse on 08/02/2024. On 11/20/2024 at 11:48 AM, The Director of Social Services was interviewed and stated their role was to advocate for Resident #118, but it was the nursing department's responsibility to initiate interventions and monitor Resident #118's behavior. On 11/21/2024 at 3:38 PM, the Director of Nursing was interviewed and stated the nurse supervisor is responsible for updating the care plans. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observations, record review, and interviews conducted during the Recertification and Complaint Survey (NY00351064) from 11/13/2024 to 11/21/2024, the facility did not ensure that residents who are unable to carry out activities of daily living receive the necessary services and assistance to maintain grooming, and personal hygiene. This was evident for 2 (Residents #48 and #169) of 7 residents reviewed for Activities of Daily Living. Specifically, Residents #48 and #169 were not provided regular showers according to their plan of care. The findings are: The facility's policy titled Activities of Daily Living with a reviewed date of 05/2023 documented a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene. The facility's policy titled Nursing Home Activities of Daily Living Policy and Procedure for Showering with a revised date of 10/2023 documented residents will be offered a shower as specified in their care plan and assistance will be provided based on the resident's level of independence and safety needs. 1.) Resident #48 was admitted to the facility with diagnoses of Cerebral Palsy (a group of conditions that affect movement and posture caused by damage that occurs to the developing brain, most often before birth) and Depression. The annual Minimum Data Set assessment (a resident assessment and care screening tool) dated 08/30/2024 documented Resident #48 was cognitively intact, required substantial/maximal assistance for showering or bathing, and had not rejected care. The assessment also documented it was somewhat important for Resident #48 to choose between a tub bath, shower, bed bath, or sponge bath. On 11/15/2024 at 10:00 AM, Resident #48 was interviewed and stated there was not enough staff to take care of them especially on the weekends. They stated they usually wait for 2 to 4 hours for staff to respond to their call for help because there is only one certified nursing assistant working on the floor. Resident #48 further stated they were not getting showers. A comprehensive care plan for self-care deficit was initiated for Resident #48 on 08/24/2023 and was last reviewed on 08/31/2024. The care plan documented Resident #48 required extensive assist of 1 staff for bathing/showers. The facility interventions included providing needed assistance during activities of daily living care. The Resident Nursing Instructions (a report containing resident care instructions that Certified Nursing Assistant must provide) with a revision date of 09/10/2024 documented Resident #48's bathing type was shower, and their bathing schedule was Mondays and Thursdays during the 7:00 AM to 3:00 PM shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Certified Nursing Assistant Accountability Record for bathing from 10/01/2024 to 11/15/2024 revealed no documented evidence that Resident #48 received showers. The record documented Resident #48 received a bed bath on 10/21/2024, 10/31/2024, and 11/07/2024. On 11/19/2024 at 10:45 AM, Licensed Practical Nurse #2 was interviewed and stated they were not made aware that Resident #48 had been refusing showers during the 7:00 AM to 3:00 PM shift or that Resident #48 would like the schedule changed to a later shift. On 11/19/2024 at 11:05 AM, Certified Nursing Assistant #10 was interviewed and stated there were instances when Resident #48 refuses to be showered and in this case, a bed bath may be provided, and the unit nurse must be notified. On 11/20/2024 at 10:06 AM, Certified Nursing Assistant #3 was interviewed and stated Resident #48 requires total care in all activities of daily living and has showers scheduled twice a week. They stated Resident #48 was given a bed bath instead of a shower during the 7:00 AM to 3:00 PM shift because Resident #48 did not want to wake up early for the shower. Certified Nursing Assistant #3 stated they do not recall offering Resident #48 a shower at a later time. Certified Nursing Assistant #3 stated the unit nurse was aware of this. On 11/20/2024 at 10:17 AM, Certified Nursing Assistant #11 was interviewed and stated Resident #48 does not refuse any care, but the Resident wanted their shower during the evening shift. They stated it has been a while since they had given Resident #48 a bed bath. Certified Nursing Assistant #11 further stated they were not sure if the nurse knew that Resident #48 wants to have their shower in the evening, or if the Resident's shower schedule had been moved to the evening shift. 2.) Resident #169 was admitted to the facility with diagnoses of Non-Alzheimer's Dementia, Depression, and Bipolar Disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). The quarterly Minimum Data Set assessment dated [DATE] documented Resident #169 had severely impaired cognition, was dependent for showering/bathing, incontinent of bowel and bladder, and had not rejected care. The annual Minimum Data Set assessment dated [DATE] documented it was somewhat important for Resident #169 to choose between a tub bath, shower, bed bath, or sponge bath. On 11/13/2024 at 10:45 AM, Resident #169 was observed awake in the room, lying in bed. Resident #169 appeared disheveled and smelled of urine. A comprehensive care plan for self-care deficit was initiated for Resident #169 on 09/20/2023 and was last reviewed on 07/05/2024. The care plan documented Resident #169 required extensive assistance of 1 or 2 staff for bathing/showers. The facility interventions included providing needed assistance during activities of daily living care. The Resident Nursing Instructions with a revision date of 05/26/2024 documented Resident #169 required partial/moderate assistance with 1 person physical assist for bathing. Their bathing type was shower, and their bathing schedule was on Tuesdays and Fridays during the 7:00 AM to 3:00 PM shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Certified Nursing Assistant Accountability Record for bathing from 10/01/2024 to 11/15/2024 revealed Resident #169 was showered on 10/15/2024, 10/20/2024, and 10/29/2024, and bed baths were given on 10/01/2024, 10/21/2024 and 11/12/2024. On 11/18/2024 at 11:42 AM, Certified Nursing Assistant #12, who had been assigned to Resident #169, was interviewed and stated Resident #169 does not refuse any care and has been given showers but cannot specify when. Certified Nursing Assistant #12 stated they were not sure if Resident #169 was given showers according to their schedule. On 11/18/2024 at 10:57 AM, Licensed Practical Nurse #3 was interviewed and stated they did not know the Certified Nursing Assistants were not giving Resident #169 showers at least twice a week according to the schedule. On 11/21/2024 at 10:27 AM, the Director of Nursing was interviewed and stated the shower schedule is based off of the Unit Shower List. They stated the unit shower list shows the shower schedule for each room number. The Director of Nursing stated Certified Nursing Assistants are responsible for providing showers to residents and must notify the nurse if a shower was not given for any reason. The Director of Nursing was not able to explain why Residents #48 and #169 did not receive showers according to their plan of care. 10 NYCRR 415.12(a)(3)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44864 Based on observation, record review, and interviews conducted during the Recertification Survey from 11/13/2024 to 11/21/2024, the facility did not ensure that a resident at risk for developing pressure ulcers, receives care, consistent with professional standards of practice, to prevent pressure ulcers. This was evident for 1 (Resident #123) of 3 residents reviewed for Pressure Ulcers. Specifically, Resident #123, who had history of healed pressure ulcers and had a care plan for use of a pressure ulcer relieving device when in bed, was observed with deflated air mattress on 3 occasions. The findings are: The facility's policy titled Mattress Management and Maintenance with a revision date of 06/2024 documented all mattresses will be regularly inspected, cleaned, and maintained to meet safety, hygiene, and comfort standards. Specialized mattresses, such as pressure relief mattresses, will be used as needed to support residents' clinical needs including prevention and management of pressure ulcers. Resident #123 was admitted to the facility with diagnoses that included Schizophrenia, Depression, and Pressure Ulcers on elbow, sacral region, and unspecified heel. The annual Minimum Data Set assessment (a resident assessment and care screening tool) dated 09/02/2024 documented Resident #123 was cognitively intact. The Minimum Data Set assessment also documented Resident #123 was at risk for developing pressure ulcers, had no unhealed pressure ulcers, and had a pressure reducing device for bed. On 11/13/2024 at 11:28 AM, Resident #123 was observed sitting in their room. Resident #123 stated they had pain because their mattress had no air in it. On observation, Resident #123's mattress appeared deflated in the middle section. On 11/14/2024 at 9:19 AM, Resident #123's mattress appeared deflated and had a pillow on top in the middle. Resident #123 stated they put 2 pillows in the middle because the mattress was too flat, and it was hurting their back. Resident #123 stated they had been telling the staff about the mattress for over a month now. On 11/15/2024 at 8:21 AM, Resident #123 was observed lying in bed awake and stated the staff still have not changed their mattress and they had to sleep with pillows on top because it was too flat. A comprehensive care plan for skin integrity, Pressure Ulcer/Injury was initiated for Resident #123 on 09/25/2022, as evidenced by at risk for impaired skin integrity. The care plan was last reviewed on 09/02/2024 and had a goal that resident will remain free from further skin impairment. The facility interventions included use of a pressure reduction cushion in wheelchair or recliner. A comprehensive care plan for self-care deficit was initiated for Resident #123 on 03/18/2021 and was last reviewed on 09/02/2024.The facility interventions included the use of pressure reduction or comfort devices as needed, and use of pressure relief or positioning devices in bed and/or chair as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Certified Nursing Accountability record for October 2024 - November 2024 had no documentation for use of pressure relieving devices. The unit's maintenance log from June 2024 - November 2024 was reviewed and did not reveal entries for Resident #123's deflated mattress. On 11/15/2024 at 8:35AM, Certified Nursing Assistant # 14 was interviewed and stated they are the primary Certified Nursing Assistant for Resident #14 for the morning shift and makes up Resident #123's bed at times. They stated they were not aware Resident #123's mattress was deflated, and had they known they would have logged it in the maintenance logbook. On 11/15/2024 at 12:23 PM, Registered Nurse #3 was interviewed and stated they are the nursing supervisor for the unit. Registered Nurse #3 stated air mattresses are monitored by the maintenance and the nursing staff. They stated if there is an issue, the licensed nurse on the unit would let the Registered Nurse Supervisor know, and a request will be placed in the maintenance log. On 11/15/2024 at 12:03 PM, the Maintenance Director was interviewed and stated the Maintenance Department does not oversee the mattresses, but if there were a concern, the nursing staff would notify the maintenance staff via the maintenance logbook. The Maintenance Director stated they do not routinely check nor track the air mattresses. On 11/20/2024 at 09:44 AM, Licensed Practical Nurse #5 was interviewed and stated they are the Wound Care Nurse who oversees the air mattresses, and the air mattresses are typically assigned to residents on admission, and as needed for prevention of pressure ulcers, and for residents with pressure ulcers. Licensed Practical Nurse #5 stated Resident #123 had a pressure ulcer that was resolved. Resident #123 continued to use an air mattress because they are at risk for pressure ulcers. Licensed Practical Nurse #5 also stated if there were any concerns with the air mattress, the staff usually would notify them. Licensed Practical Nurse #5 stated they were notified of Resident #123's air mattress on 11/15/2024 and they found a leak in the mattress. On 11/21/2024 at 11:32 AM, the Director of Nursing was interviewed and stated they, along with the Wound Care Nurse oversee the air mattresses. The Director of Nursing stated Resident #123 had a history of pressure ulcers and was provided with an air mattress. They were not aware the air mattress was not functioning. The Director of Nursing stated the Certified Nursing Assistants assigned to the resident should have identified that the mattress was not functioning, and they should have notified the nurse on the unit. 10 NYCRR 415.12(c)(1)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 33315 Based on observation, record review, and interviews conducted during the Recertification and Abbreviated Survey (NY00347302, NY00351629, and NY00351064) conducted from 11/13/2024 to 11/21/2024, the facility did not ensure that sufficient nursing staff was consistently provided to meet the residents' needs in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care. Specifically, 1) Several residents reported the facility was short staffed of Certified Nursing Assistants, especially during the evenings, and weekends, which resulted in lack of timely staff response to residents who needed assistance with toileting, bathing, and personal care. 2.) A review of the actual staffing schedules dated from 07/01/2024 to 11/21/2024 revealed staffing assignments were consistently less than the projected staffing needs specified in the Facility Assessment and on the daily staffing schedules for Certified Nursing Assistants. The findings include but are not limited to: The Facility Assessment Tool dated 10/2024 documented the facility had a bed capacity of 240 residents with an average daily census of 206. The facility assessment documented that based on their acuity levels, most residents have reduced physical function, and had behavioral health needs. The facility had no independent residents, some residents were dependent, and most residents required the assistance of 1-2 staff for activities of daily living. The Facility Assessment further documented that 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 30 licensed nurses providing direct care and 56 nurse aides. The facility's general staffing plan documented the facility would provide 2-4 Certified Nursing Assistants for 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts in Units 2, 3, 4, 5 and 6; and 2-3 Certified Nursing Assistants for Units 2 and 3 for the 11:00 PM to 7:00 AM shift; and 2-4 Certified Nursing Assistants for Units 4, 5, and 6 for the 11:00 PM to 7:00 AM shift. On 11/14/2024 at 8:20 AM, an interview was conducted with Resident #95 who stated they need assistance with toileting and showering. Resident #95 stated the facility is short staffed all day, every Saturday and Sunday. Resident #95 stated they can perform a few of their personal care activities themselves. Sometimes they will need some toiletries and bathing items but there will be no single staff on the unit to help them. Resident #95 also stated because the nurse in their unit arrives late, they had to go to another unit to ask for toiletries. On 11/15/2024 at 10:00 AM, an interview was conducted with Resident #48 who stated they needed assistance for toileting and showering, they use a wheelchair and are dependent on staff for transfers. Resident #48 stated there is not enough nursing staff especially on the weekends. They stated they have to wait for 2 to 4 hours for someone to respond to their call bells, and if a Certified Nursing Assistant finally showed up, they were told to wait. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/15/2024 at 3:30 PM, an interview was conducted with Resident #83 who stated they need help with toileting, hygiene, and showering. Resident #83 stated there is not enough nursing staff especially on weekends. Resident #83 stated they could not give specific dates but stated no one answers the call bells. Resident #83 stated they often waited until close to noon to get up. Resident #83 stated sometimes they had not been toileted, and they sometimes skip showers because there is no one to assist them. They stated no one is available to help them get toiletries or what they needed to shower. On 11/15/2024 at 3:45 PM, an interview was conducted with Resident #178 who stated the facility is always short staffed especially on the weekends. Resident #78 stated there were times they only had 1 Certified Nursing Assistant on the unit. They stated they had to wait for so long before they could get help. Resident #78 stated they sometimes skip a shower because there is no one to assist them. On 11/15/2024 at 3:50 PM, an interview was conducted with Resident #150 who stated there is not enough nursing staff mostly in the evenings. Resident #150 stated they liked to get washed and dressed earlier than 11:00 in the morning and always ate breakfast in their room. Resident #150 stated this has not been happening most of the time as they have to wait for a staff member to come and help them. A review of the actual staffing schedules from 07/01/2024 to 11/21/2024 revealed consistently low staffing for Certified Nursing Assistants during the days, nights, and weekends. The actual staffing schedule documented the following (each unit's census ranged from 36-45 residents): On 07/13/2024, Saturday, 11:00 PM to 7:00 PM shift, there were 4 Certified Nursing Assistants scheduled in Unit 3. Documentation revealed 1 Certified Nursing Assistant worked in Unit 3, which had a census of 45 residents. On 07/21/2024, Sunday, 7:00 AM to 3:00 PM shift, there were 4 Certified Nursing Assistants scheduled for each unit (Units 2,3,4,5, and 6). Documentation revealed 2 Certified Nursing Assistants worked in each unit for that shift. On 08/18/2024, Sunday, 7:00 AM to 3:00 PM shift, there were 4 Certified Nursing Assistants scheduled for each unit (Units 2, 3, 4, and 5). Documentation revealed 2 Certified Nursing Assistants worked in each unit for that shift. On 10/06/2024, Sunday, 7:00 AM to 3:00 PM shift, there were 4 Certified Nursing Assistants scheduled for each unit (Units 2 and 3). Documentation revealed 2 Certified Nursing Assistants worked in each unit for that shift. On 10/30/2024, Wednesday, 7:00 AM to 3:00 PM shift, there were 4 Certified Nursing Assistants scheduled for each unit (Units 2 and 3). Documentation revealed 2 Certified Nursing Assistants worked in each unit for that shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/03/2024, Sunday, 7:00 AM to 3:00 PM shift, there were 4 Certified Nursing Assistants scheduled in Unit 2. Documentation revealed 2 Certified Nursing Assistants worked in the unit for that shift. On 11/10/2024, Sunday, 11:00 PM to 7:00 AM shift, there were 4 Certified Nursing Assistants scheduled for each unit (Units 2, 3, and 5). Documentation revealed 2 Certified Nursing Assistants worked in each unit for that shift. On 11/16/2024, Saturday, 11:00 PM to 7:00 AM shift, there were 3 Certified Nursing Assistants scheduled for each unit (Units 2 and 5). Documentation revealed 1 Certified Nursing Assistant worked in each unit for that shift. On 11/18/2024 at 2:38 PM, an interview was conducted with Certified Nursing Assistant #6 who stated there were times when there were only 2 Certified Nursing Assistants working in Unit 2, and there was a time when there was only 1 working during the day shift. They stated they try to manage but there will definitely be a delay in caring for residents when there is not enough aides. On 11/18/2024 at 3:10 PM, an interview was conducted with Certified Nursing Assistant #8 who stated they work in the evening and night shift. They stated the staffing had been worse and the aides were reduced from 4 in the morning and evening shift, to only 2 aides per shift in the units. Certified Nursing Assistant #8 stated it was hard to answer call bells and try to give showers to residents because of this. On 11/20/2024 at 11:21 AM, an interview was conducted with Licensed Practical Nurse #1 who stated they work 5 to 6 days a week and the units are supposed to be staffed with 3 to 4 Certified Nursing Assistants. They stated they often have only 2 Certified Nursing Assistants working in the unit, and they sometimes had to stop what they are doing to help the Certified Nursing Assistants. On 11/20/2024 at 11:39 AM, an interview was conducted with Registered Nurse #3 who stated the residents had been complaining there is not enough Certified Nursing Assistants to help them out. They stated the staff, who are mostly from the agency, calls out and are not being replaced. Registered Nurse #3 stated there must be at least 3 Certified Nursing Assistants in each unit for the day and evening shift, and 2 for the night shift. However, they only have 2 for the day and evening, and only 1 at night for each unit and the licensed nurses help the Certified Nursing Assistants with their tasks. On 11/20/2024 at 12:30 PM, an interview was conducted with the Staffing Coordinator who stated they are aware of the staffing plan, and that there should be 4 Certified Nursing Assistants in each unit during the day and evening shifts, and 3 for the night shift. They stated 40% of their nursing staff are from a staffing agency and sometimes, the agency staff does not show up for work. On 11/20/2024 at 1:00 PM, an interview was conducted with the Director of Nursing who stated residents have higher expectations and wanted services that are beyond the standard care that the nursing home can offer. The Director of Nursing stated the staffing par level for nursing assistants for the day and evening shifts is 2 to 4 aides. They stated they are not locking the staffing to 2 aides, but their goal is to have 4. The Director of Nursing stated they projected 2 to 3 nursing assistants for the night shift, but the nursing assistants occasionally call out and they are not being notified timely, and there is no commitment from the staff (continued on next page)

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Grand Manor Nursing & Rehabilitation Center	700 White Plains Road Bronx, NY 10473

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/21/2024 at 11:14 AM, the Administrator was interviewed and stated the facility made efforts to improve the staffing since the last recertification survey and that hiring and new employee orientation had improved since they hired the new In-service Coordinator. The Administrator stated the challenge they have is the staff do not want to be directly hired. Staff would rather sign up with an agency because the pay is better. The Administrator also stated most of the agency staff are not putting in the commitment as they can go somewhere else. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 33315 Based on record review and staff interviews conducted during the Recertification Survey from 11/13/2024-11/21/2024, the facility did not ensure performance reviews of every nurse aide was conducted at least once every 12 months, and that regular in-service education was provided based on the outcome of these reviews. This was evident for 5 (Certified Nursing Assistants #8, #15, #16, #17, and #18) of 5 Certified Nursing Assistants reviewed for nurse aides' training requirements. The findings are: The facility policy titled In-Service Training: Nurse Aide dated 06/2024 documented that performance reviews must be completed for nurse aides at least every 12 months. The Facility Assessment Tool dated 10/2024 documented that performance reviews will be conducted, and that the reviews will provide structured feedback and that the process will highlight individual strengths and identifies areas needing improvement. The facility assessment did not specify the frequency of performance reviews. A review of personnel files for Certified Nursing Assistants #8, #15, #16, #17, and #18 showed no documented evidence that annual reviews were completed. During an interview on 11/21/2024 at 2:00 PM, the Director of Human Resources stated Certified Nursing Assistants #8, #15, #16, #17, and #18 were hired years ago and that they could not locate any performance reviews in their personnel files. During an interview on 11/21/2024 at 2:30 PM, the Director of Nursing stated the Nursing Department is responsible for conducting performance evaluations for Certified Nursing Assistants. The Director of Nursing could not explain why the performance reviews were not completed. During an interview on 11/21/2024 at 1:24 PM, the Administrator stated the Nursing Department is responsible for ensuring performance evaluations were conducted annually for Certified Nursing Assistants. The Administrator stated the facility went through many personnel changes and the responsibility of performance reviews fell through the cracks. 10 NYCRR 415.26(c)(2)(iii)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 44843 Based on interview and record review conducted during the Recertification and Complaint (NY00350179) Survey from 11/13/2024 to 11/21/2024, the facility did not ensure that each resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychological well-being, in accordance with the comprehensive assessment and plan of care. This was evident in 1 (Resident #118) of 6 residents reviewed for abuse. Specifically, Resident #118 exhibited multiple incidents of behavior symptoms such as stealing from other residents and had been involved in resident-to-resident altercations. The facility did not evaluate the effectiveness of the interventions to address Resident #118's behavior, lacked individual approach in the care plan to address Resident #118's behavior, and lacked monitoring and supervision of Resident #118's behavior that may provoke reaction from other residents. The findings are: The facility's policy titled Behavioral Health Policy with a reviewed date of 06/2024 documented the facility provides behavioral health services within its capacity. The interdisciplinary team conducts assessments and develops care plans tailored to residents' behavioral health needs. The policy documented the staff monitors and document interventions and behavioral symptoms in the medical record. Resident #118 was admitted to the facility with diagnoses which included Violent Behavior, Unspecified Mood Disorder, and Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). The quarterly Minimum Data Set assessment (a resident assessment and care tracking tool) dated 08/09/2024 documented Resident #118 had moderate impairment in cognition and required supervision with most activities of daily living. The Minimum Data Set did not document any behavioral symptom. A nurse's note dated 08/02/2024 at 12:52 PM documented Resident #118 was hit in the head by another resident with a cane at around 11:20 AM. The undated facility's Summary of Investigation documented on 08/02/2024 at around 11:15 AM, Resident #118 was involved in an altercation with Resident #151 in the basement elevator. The facility investigation concluded there was cause to believe resident abuse had occurred. The investigation documented Resident #118 insisted to ride the elevator, but Resident #151 told Resident #118 that the door would not close. Resident #118 then grabbed a $20 bill from Resident #151's hand. Resident #151 hit Resident #118 with a cane. A care plan for victimize/victimization was initiated for Resident #118 on 06/27/2023 and was last reviewed on 11/08/2024. The facility interventions include identifying triggers for behavior, room change as appropriate, and close observation on every half hour check for behavior and safety monitoring. The care plan notes documented that on 09/01/2023, Resident #118 was accused by another resident of stealing their wallet. This resulted in Resident #118 being pushed by the other resident and falling to the floor. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence the care plan was updated following the incident on 08/02/2024. A care plan for mood and behavior patterns were initiated for Resident #118 on 06/27/2023 and was last reviewed on 08/09/2024. The care plan documented the Resident had the behavior of taking multiple towels and bed sheets and attempted to snatch a candy from another resident. The facility interventions included monitoring changes in cognition, mood, and behavior and to notify the physician; encourage daily activities, and to encourage socialization with peers. The care plan notes documented Resident #118 had a history of non-compliance with care and exposing their private parts while in the day room. A care plan for victimization/aggressive behavior was initiated for Resident #118 on 06/27/2023 and was last reviewed on 08/29/2024. The facility interventions included psychiatric evaluation, 1:1 monitoring, and protecting from overstimulation. The care plan notes documented Resident #118 had been involved in an altercation with another resident on 09/15/2023 and 04/21/2024. There was no documented evidence of close observation, or every half hour check as indicated in the care plan interventions for victimization. There was no documented evidence of 1:1 monitoring as stated in the care plan interventions for victimization/aggressive behavior. A review of the comprehensive care plans revealed no additional intervention put in place to address Resident #1's behavior after the resident-to-resident altercation on 08/02/2024. On 11/18/2024 at 11:35 AM, Certified Nursing Assistant #3 was interviewed and stated Resident #118 was alert and oriented to person, place, and time and does not follow instructions. Certified Nursing Assistant #3 stated Resident #118 had behavior issues like wandering to other units and stealing things from other residents or staff when no one was inside the room. Certified Nursing Assistant #3 stated they redirect Resident #118 when the Resident is in the unit, however they do not monitor Resident #118 when they leave the unit. On 11/20/2024 at 10:29 AM, Licensed Practical Nurse # 2 was interviewed and stated Resident #118 liked to steal things from other residents in their unit and also goes to other floors to steal things. Licensed Practical Nurse #2 stated they do not know if Resident #118 is monitored when they leave the unit and go to other floors. On 11/21/2024 at 03:06 PM, Licensed Practical Nurse #1 was interviewed and stated they would see Resident #118 in their unit, but they do not monitor them. On 11/20/2024 at 11:42 AM, Registered Nurse #1 was interviewed and stated they were not sure if the staff on other floors were aware of Resident # 118's behavior and how Resident #118 was monitored when they went to other floors. On 11/20/2024 at 11:48 AM, The Director of Social Services was interviewed and stated Resident #118 often steals and they were aware of the altercation Resident #118 had with another resident. They stated it was the nursing department's responsibility to initiate interventions and monitor Resident #118's behavior. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/2024 at 03:38 PM, the Director of Nursing was interviewed and stated they were aware of Resident #118's behavior issues such as stealing and exposing themselves. The Director of Nursing stated the nurse supervisor is responsible for updating the care plans to manage Resident #118's behavioral issues. The Director of Nursing did not answer when they were asked how Resident #118 was monitored and supervised when they leave their unit. 10 NYCRR 415.12(f)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44842 Based on observation, record review, and interviews conducted during the Recertification Survey from 11/13/2024 through 11/21/2024, the facility did not ensure that all medications and biologicals used in the facility were safely stored. Specifically, insulin pens were not stored in a sanitary manner to prevent cross-contamination. This was evident during observations (Unit 5) conducted for the Medication Storage Task. The findings are: The facility policy and procedure titled Medication Storage with a revision date of 09/07/2023 documented that medication must be stored in accordance with manufacturer's specifications, sufficient to ensure proper sanitation, and secured in locked areas in compliance with State and Federal requirements and accepted professional standards of practice. On 11/19/2024 at 10:52 AM, an observation was conducted of the medication cart on the 5th floor. Four different resident insulin pens were observed stored together in a compartment in the top drawer of the medication cart. On 11/19/2024 at 10:53 AM, Registered Nurse #1 who was administering medications stated they did not notice the insulin pens were not separated in individual plastic bags because they were busy. Registered Nurse #1 stated the insulin pens must be stored separately in individual plastic bags. On 11/19/2024 at 5:18 PM, the Director of Nursing was interviewed and stated there is no such thing to store insulin pens in individual plastic bags. 10 NYCRR 415.18(e)(1-4)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 44842 Based on observations, record review, and interviews conducted during the Recertification and Complaint Survey from 11/13/2024 to 11/21/2024, the facility did not ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was evident during review of Activities of Daily Living, Staffing, Infection Control, Medication Storage, and Quality Assurance. Specifically, 1.) The Administration did not ensure the facility was sufficiently staffed to meet the residents' needs. In addition, the Administration did not monitor and enhance the quality of care and services as indicated by repetition of deficiencies that were cited on previous recertification surveys (F641, F657, F725, and F761) 2.) Nursing Services were not administered adequately to ensure that assistance with activities of daily living were consistently provided to the residents, that drugs were stored in a sanitary manner, infection control practices were maintained, and performance evaluations were completed for the nursing assistants. The findings are: 1. Cross refer to F641, F657, F725, F761, F851 and F725. The Administration was aware of the extent of the staffing issue but failed to provide evidence of facility's staff retention efforts. There was lack of evidence the facility's previous citations were continuously monitored to prevent recurrence. 2. Cross refer to F561, F657, F677, F686, F730, F740, and F880 The Director of Nursing was aware of the extent of the staffing issue but was unaware of the extent on how it impacted resident care and services. Interview with the Director of Nursing revealed they were unaware of the issues identified in F561, F657, F677, F686, F730, and F880 indicating lack of oversight. On 11/21/2024 at 1:05 PM, during an interview with the Administrator, they stated they were aware of the repeated deficiency on staffing issue and had contracted 5 staffing agencies to fill the Certified Nursing Assistant and Licensed Practical Nurse positions. The Administrator stated weekends are challenging for staff because of the last minute call outs. The Administrator stated they were unaware of the newly found issues and that these issues were isolated. The Administrator stated they hired consultants to assist with the facility's clinical and life safety issues. On 11/20/2024 at 1:00 PM, the Director of Nursing stated during the interview that residents have higher expectations and wanted services that are beyond the standard care that nursing homes can offer. The Director of Nursing stated they were not aware of the infection control issue cited in F880, stated it was an isolated incident and the staff must be new. They stated they were unaware of the deflated mattress indicated in F686, and the resident did not bring the issue to their attention. The Director of Nursing stated care plans not being updated was something new. The Director of Nursing was not able to respond when asked how a resident with behavioral issues is being supervised when they are off the unit. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10 NYCRR 415.26

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 44842 Based on observations, record reviews, and interviews conducted during the Recertification and Complaint Survey from 11/13/2024 to 11/21/2024, the facility did not ensure it has an active governing body that is responsible for establishing and implementing policies regarding the management of the facility. Specifically, based on the multiple deficient practices that were identified during the Recertification Survey, there was inconsistent communication between the facility Administrator and the Governing Body to ensure management of the facility and regulatory compliance. The findings are: The facility policy titled Quality Assurance and Performance Improvement with a reviewed date of 04/2024 documented the Governing Body and/or executive leadership is responsible and accountable for the Quality Assurance and Performance Improvement program. Governing oversight responsibilities include ensuring the program identifies and prioritizes problems and opportunities that reflect organizational processes, functions, and services provided to residents based on performance indictor data, and resident and staff input, and other information and ensuring corrective actions address gaps in systems and are evaluated for effectiveness. On 11/14/2024 at 11:15 AM, a Special Resident's Council Meeting was held with the State Surveyor and 12 residents in attendance. The 12 residents belong to different units in the facility. The residents reported call lights were not answered in a timely manner especially on weekends, and that they are left in bed all day on weekends due to not having enough staff to assist them. The residents stated the facility does not act promptly on their concerns and there was no follow-up made from the facility staff. A review of the minutes of the Resident Council meeting held in August 2024 revealed the residents reported care concerns regarding being left in bed, nursing staff talking on their cell phones, poor customer service towards residents, and room cleanliness. On 11/21/2024 at 12:39 PM, during an interview with the Operator/Owner of the facility, they stated they attend Quality Assurance and Performance Improvement meeting once a year. They stated the Administrator submits a typed report of monthly Quality Assurance meetings. The Operator/Owner stated the Administrator is held accountable to ensure the facility is complying with the Federal and State regulations. 10NYCRR 415.26(b)(3)(1)

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 33315 Based on record review and interviews conducted during the Recertification Survey from 11/13/2024 to 11/21/2024, the facility did not ensure that the direct care staffing information based on payroll data was submitted based on the schedule specified by the Centers for Medicare and Medicaid Services. Specifically, the facility failed to submit the direct care staffing data for Quarter 3 2024 (April 1 - June 30) in a timely manner. The findings are: The Centers for Medicare & Medicaid Services Electronic Staffing Data Submission Payroll-Based Journal, Long Term Care Facility Policy Manual version 2.6 dated 06/2022 documented Section 6106 of the Affordable Care Act requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate. Staffing and census data will be collected for each fiscal quarter. The deadline for submissions must be received by the end of the 45th calendar day (11:59 PM Eastern Time) after the last day in each fiscal quarter in order to be considered timely. The Centers for Medicare and Medicaid Services Payroll Based Journal Staffing Data Report documented there was no data submitted by the facility for the fiscal year Quarter 3 2024 (April 1 - June 30). During an interview on 11/18/2024 at 10:44 AM, the Director of Human Resources stated they are responsible for making sure all of the time management records of staff are completed and sent to the Administrator for submission. The Director of Human Resources also stated the Administration is responsible to make sure the Payroll Based Journal is submitted on time. During an interview on 11/21/2024 at 11:28 AM, the Administrator stated they are responsible for submitting Payroll Based Journal. They stated they were aware of the deadline to submit the direct care staffing data but was unable to explain why they failed to submit the direct care staffing data for Quarter 3 2024. The Administrator stated it was an oversight. 10 NYCRR 400.2

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 44842 Based on observations, record review, and interviews conducted during the Recertification and Complaint Survey from 11/13/2024 to 11/21/2024, the facility did not ensure that the quality assurance and performance improvement program identified and prioritized problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, resident and staff input, and other information. Specifically, the facility had widespread deficiencies in the areas of Nursing Services, Administration, and Infection Control. In addition, the facility had deficiencies from previous Recertification surveys that were repeatedly cited in the current survey (F641, F657, F725, F761, and F865). Also, the facility failed to ensure the Governing Body's oversight of the facility's quality assurance and performance improvement program and activities. The findings are: The facility's Quality Assurance and Performance Improvement Plan with a revision date of 05/04/2023 documented the plan was designed to provide guidance in assessing and improving overall quality of care and quality of resident life. Focus areas will include all systems that affect resident and family satisfaction, quality of services and care provided, and all areas that affect the quality of people living and working in the organization. The Administrator will ensure that the Quality Assurance and Performance Improvement Plan is reviewed minimally on an annual basis by the Quality Assurance and Performance Improvement Committee. 1. For widespread deficiencies, cross refer to F641, F725, F730, F835, F837, and F880. 2. For repeated deficiencies, cross refer to F641, F657, F725, F761, and F865. The facility was not able to produce documented evidence of systems and reports demonstrating identification, reporting, investigation, analysis, and corrective actions of the widespread and repeated deficiencies. During an interview on 11/20/2024 at 1:00 PM, the Director of Nursing stated residents have higher expectations and wanted services that are beyond the standard care that nursing homes can offer. The Director of Nursing stated they were not aware of the infection control issue cited in F880, it was an isolated incident, and the staff must be new. During an interview on 11/21/2024 at 1:05 PM, the Administrator stated they gather information on what issues to address by monitoring the 24-hour report, accidents and incidents, audits, and resident council meetings. They stated they were aware of the repeated deficiency on the staffing issue and are working with other agencies to fill the Certified Nursing Assistant and Licensed Practical Nurse positions. The Administrator stated the newly found issues were isolated and they were not aware of them. The Administrator stated the Operator/Owner of the facility does not attend the Quality Assurance meetings but receives copies of the minutes after every monthly meeting. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/21/2024 at 12:39 PM, the Operator/Owner stated they attend the Quality Assurance and Performance Improvement meeting once a year. They stated the Administrator submits a copy of the minutes monthly. The Operator/Owner stated they review all completed audits with the Administrator, and the Administrator is held accountable in ensuring the facility complies with State and Federal regulations. 10 NYCRR 415.27 (a-c)

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	11/21/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44864 Based on observation, record review, and interviews conducted during the Recertification Survey from 11/13/2024 -11/21/2024, the facility did not ensure infection control practices and procedures were maintained. This was evident for 7 (Residents #69, #47, #92, #412, #87, #7, #74) of 10 residents, from 3 different units, observed for medication administration. Specifically, 1.) Licensed Practical Nurse #4 failed to sanitize the blood pressure machine and cuff after each resident use. 2.) Registered Nurse #5 failed to sanitize the glucometer (a medical device used to measure the amount of sugar in the blood) after each resident use. 3.) Licensed Practical Nurse #1 failed to sanitize the blood pressure machine and cuff after each resident use. The findings are: The facility's policy titled Equipment Cleaning last reviewed 06/2024 documented that any equipment shared between residents must be cleaned and disinfected between uses to prevent cross contamination. The policy also documented that all resident care equipment, including example blood pressure monitors, must be cleaned and disinfected after each use. 1.) On 11/15/2024 at 9:12 AM, during medication administration observation on Unit 4, Licensed Practical Nurse #4 entered Resident #69's room, introduced themselves and told the Resident that they were taking their blood pressure. Licensed Practical Nurse #4 took Resident #69's blood pressure, administered their medication, and left the room. Licensed Practical Nurse #4 sanitized their hands, then placed the blood pressure machine and cuff on top of the medication cart without sanitizing them. On 11/15/2024 at 9:32 AM, Licensed Practical Nurse #4 entered Resident #47's room, introduced themselves and told the Resident that they were taking their blood pressure. Licensed Practical Nurse #4 took Resident #47's blood pressure, administered their medication, and left the room. Licensed Practical Nurse #4 sanitized their hands, then placed the blood pressure machine and cuff on top of the medication cart without sanitizing them. On 11/15/2024 at 9:52 AM, Licensed Practical Nurse #4 addressed Resident #92 who was in the hallway and told the Resident they were going to take their blood pressure and administer their medication. Licensed Practical Nurse #4 applied the blood pressure cuff and took Resident #92's blood pressure, then administered their medication. Licensed Practical Nurse #4 sanitized their hands, then placed the blood pressure machine and cuff on top of the medication cart without sanitizing them. On 11/15/2024 at 9:54 AM, Licensed Practical Nurse #4 stated during the interview that they forgot to sanitize the blood pressure machine and cuff after each resident's use. (continued on next page)

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	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2.) On 11/15/2024 at 11:53 AM, during medication administration observation in Unit 3, Registered Nurse #5 was observed administering Resident #412's finger stick blood sugar (a method of drawing drops of blood to monitor blood sugar). Registered Nurse #5 entered Resident #412's room, announced that they were going to do the finger stick, placed a box on resident's table, then washed their hands. Registered Nurse #5 donned a pair of gloves and took the glucometer, a lancet and an alcohol pad from the box that was placed on the resident's table and did the finger stick. Registered Nurse #5 then removed their gloves, placed the glucometer back in the box, and left the resident's room. Registered Nurse #5 did not clean or sanitize the glucometer before placing it back in the box and did not perform hand hygiene after removing their gloves and before leaving the room. On 11/15/2024 at 12:06 PM, Registered Nurse #5 was observed administering Resident #87's finger stick. Registered Nurse #5 entered Resident #87's room and announced that they were going to do the finger stick. Registered Nurse #5 then placed the box containing a glucometer on the resident's table, washed their hands, and donned a pair of gloves. Registered Nurse #5 then took the glucometer, a lancet, and an alcohol pad from the box that was placed on the resident's table and did the finger stick. Registered Nurse #5 then removed their gloves, placed the glucometer back in the box, and left Resident #87's room. Registered Nurse #5 did not clean or sanitize the glucometer before placing it back in the box and did not perform hand hygiene after removing their gloves before leaving the room. On 11/15/2024 at 12:16 PM, Registered Nurse #5 was interviewed and stated they are aware that they are supposed to clean the glucometer after each resident's use. 3.) On 11/18/2024 at 8:49 AM, during medication administration observation in Unit 2, Licensed Practical Nurse #1 took the blood pressure machine and cuff from the medication cart, went to Resident #7's room, introduced themselves and told Resident #7 that they were going to take their blood pressure and administer their medications. Licensed Practical Nurse #1 proceeded to apply the blood pressure cuff to Resident #7's arm, took the blood pressure, then administered their medication. Licensed Practical Nurse #1 sanitized their hands, then placed the blood pressure machine and cuff on the medication cart without sanitizing them. On 11/18/2024 at 8:55AM, Licensed Practical Nurse #1 entered Resident #74's room, introduced themselves, and told Resident #74 they were going to take their blood pressure and administer their medications. Licensed Practical Nurse #1 proceeded to apply the blood pressure cuff to Resident #74's arm and took their blood pressure. Licensed Practical Nurse #1 then administered Resident #74 their medication, sanitized their hand, and placed the blood pressure machine and cuff on the medication cart without sanitizing them. On 11/18/2024 at 8:55, AM Licensed Practical Nurse #1 was interviewed and stated they received education that they must clean the blood pressure cuff and machine after each resident's use, and that they just missed it. On 11/21/2024 at 11:45 AM, the Director of Nursing and Infection Prevention Nurse, was interviewed and stated that licensed nurses received in-service education on cleaning the equipment like blood pressure machine and glucometer, between resident usage. 10 NYCRR 415.19 (a)(1-3)