| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335744 | A. Building<br>B. Wing | 12/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Grand Manor Nursing & Rehabilitation Center | 700 White Plains Road<br>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) |
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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Based on observation, record review, and interviews, the facility failed to ensure a qualified dietitian or another clinically qualified nutrition professional, including a director of food and nutrition services, was employed part-time, full-time, or as a consultant. Specifically, the facility has employed a non-registered dietician as their full-time dietician and food service director without the oversight of a registered dietician or certified food service director since September 2025.The findings are:The undated facility policy, titled Food Service Management, documented that the food and nutrition services department head must meet New York State Department of Health requirements for food service manager, and plans, organizes, supervises, and directs all administrative and operational activities of the Food and Nutrition Services Department.A review of the Facility Survey Report, New York State Department of Health Form 1550, revealed it was signed by the facility operator and principal partner and dated 12/01/2025. The report lists the license number of the previous registered dietician (Facility Dietician #1) and designates them as the Registered Dietician and Food Service Director. The report does not list any other staff as the designated dietician or food service director.During an interview on 12/03/2025 at 2:30 PM, Facility Dietician #2 stated that they are not a registered dietician, but they had been employed at the facility since 2022 on a per diem basis and worked two (2) days a week. They stated that they were currently hired to work part to full time, because there has not been a full-time registered dietician or food service director in the facility since September 2025. Facility Dietician #2 further stated that they perform all tasks related to residents, such as dietary assessments, assess for allergies, diet recommendations, and weight monitoring. However, they do not perform any administrative duties such as meetings, supervision of staff or review of policies and procedures.During an interview on 12/04/2025 at 3:01 PM, the Medical Director stated that they were told the registered dietician was terminated in October 2025, and that they were expecting an immediate replacement for the position. The Medical Director also stated that they have discussed the issue with the facility Administrator and the Director of Nursing but have not been provided with any details on when the position will be filled. The Medical Director further stated that they review residents' weights, prescribed diets, care plans and they attend the monthly weight meetings to ensure that residents' nutritional needs are met, and significant weight changes are addressed.During an interview on 12/09/2025 at 11:33 AM, the Administrator stated that currently, they do not have a registered dietician employed at the facility. The previous food service director was also the registered dietician, and they resigned at the end of September 2025. Since that time, the facility has not employed another registered dietician. The Administrator stated they had contracted with a nutrition consultant who was able to find a registered dietician for the facility to hire, However, they were told the person would be able to start later this week. The Administrator stated that they intend to hire a new food service director within two (2) weeks. The facility will then have a full time and part time registered dietician. The Administrator further stated that the current facility dietician, who is not registered, has been employed at the facility per diem since 2020.10 NYCRR 415.14(a)(1)(2) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, record review, and interviews, the facility failed to ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety. Specifically, 1.) The walk-in refrigerator contained prepared food items and defrosting meats that were unlabeled and undated. 2.) A pantry refrigerator contained expired, undated and unlabeled resident food.The findings are:The facility's policy and procedure titled Safe Defrosting and Food Labeling, with a revision date of 01/2025, documented that all potentially hazardous foods should be thawed and labeled safely to prevent foodborne illness and comply with Department of Health and regulatory requirements. All prepared, opened, or repackaged foods stored in refrigeration, freezers, or dry storage must be clearly labeled with the product name, date prepared or opened, and use-by/discard date. All frozen food items placed into the freezer must be labeled with the product name and the date frozen. When frozen items are removed from the freezer and placed into refrigeration for thawing, the item must also show the thaw date if held more than 24 hours. Any food found unlabeled, incorrectly dated or past the use-by/discard date must be immediately discarded. It is the responsibility of all food service staff to ensure food is properly labeled and dated at the time of preparation, opening, freezing, or repackaging. The Food service Director or designee will conduct routine checks (daily refrigerator/freezer round) to monitor compliance. The facility's policy and procedure titled Outside Food and Beverage with a revision date of 06/2025, documented established rules for bringing outside food and beverages into the facility in order to protect the health, safety, and dietary needs of residents. Outside food and beverages may be brought into or delivered to the facility for residents, subject to this policy. Any outside food left at the facility to be stored in the facility refrigerator for later use must be labeled with the resident's name and the date. Unlabeled or unidentified food may be discarded. The facility's undated policy and procedure titled Food Pantry Refrigerators and Temperature Logs, documented that all foods in the pantry refrigerators more than three (3) days old will be discarded. 1.) During an observation in the kitchen on 12/01/2025 at 9:20AM, the following was noted:The Walk-in Refrigerator contained:One (1) unlabeled quarter pan of cooked beans dated 11/26/2025.One (1) unlabeled, undated full pan of raw seasoned pork.Unlabeled and undated defrosting meats including: two (2) whole turkey breasts, two (2) two-pound packages of sliced ham, three (3) two-three-pound packages of sliced bologna, three (3) whole pork loins.On 12/01/2025 at 9:53 AM, the Dietary Supervisor was interviewed and stated that all items should be labeled with the product name and dated with the date opened, date prepared, date placed in refrigerator for defrost and date to be removed from defrost. All food items that are unlabeled and undated should be discarded immediately. Unused dated food items should be discarded within 72 hours, and defrosted food items should be removed from the refrigerator within 48 hours. The Food Service Supervisor also stated that they perform kitchen rounds daily as it is their responsibility to ensure compliance and that they performed kitchen rounds today which included observation of the walk-in refrigerator, but they did not see the unlabeled, undated and defrosting food items. On 12/01/2025 at 11:55 AM, a follow up interview was performed with the Dietary Supervisor who stated that they spoke with Dietary Aide #1 by telephone who was responsible for placing the unlabeled, undated meats in the refrigerator. The Dietary Supervisor stated that Dietary Aide #1 reported that they placed a paper with the date under the food items and is not sure what happened to the paper. The Dietary Supervisor further stated that the product name and dates should have been securely labeled on the food items to ensure proper and sanitary storage, use and disposal. On 12/09/2025 at 2:15 PM and 3:37 PM, a telephone interview was attempted with Dietary Aide #1. The telephone calls placed were unanswered.2.) On 12/05/2025, the following were noted during the observation of the Sixth Floor pantry refrigerator:There were two (2) plastic bags labeled with Resident #54's name. The first bag contained two (2) one-pound open packages of Swiss cheese with a sell by date of<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 11/25/2025; an open package of ham with a sell by date of 11/05/2025, an open container of butter with olive oil with a best buy date of 08/25/2025; an undated large bowl of peas and rice, and an undated container with soup. The second bag contained an undated bowl of seafood salad and a bowl of rice. During an interview on 12/05/2025 at 2:45 PM, Licensed Practical Nurse #1 stated that resident food contained in the pantry refrigerator should be discarded within three (3) days. The nurses check the refrigerators daily for temperatures and expired, unlabeled, undated food and beverages but sometimes the residents will not allow the staff to discard the food despite having been spoken to by supervisors. During an interview on 12/05/2025 at 2:55 PM, Registered Nurse Supervisor #3 stated that the pantry refrigerators should be checked daily by the staff for adequate temperatures and to ensure resident food items are labeled, dated and discarded timely. Registered Nurse #3 also stated that sometimes, they check to see if the staff has performed the pantry refrigerator tasks, but they have been on vacation from October to 11/25/2025 and have not followed up since their return to see if the nurses are discarding resident food within three (3) days. During an interview on 12/06/2025 at 3:51 PM, the Dietary Supervisor stated that labeled and dated resident food can remain in the pantry refrigerators for three (3) days and then the food must be discarded. The Dietary Supervisor also stated that the dietary staff places snacks and nourishments in the pantry refrigerators daily and at that time they check that the refrigerated food is dated and labeled with the resident name and room number and that the food is discarded within three (3) days. The Dietary Supervisor also stated that resident food is not discarded by the floor staff as they are told that the residents become agitated. The Dietary Supervisor further stated that this issue has to be resolved with residents and families by nursing and social work. During an interview on 12/09/2025 at 3:15 PM, the Director of Nursing stated that each unit has a certified nursing assistant assignment every shift to check the pantry refrigerators for dated, labeled resident food and to discard the food items after three (3) days. The Director of Nursing also stated that the nursing supervisor should perform rounds to ensure compliance and follow up with the resident and families if there is an issue. The Director of Nursing further stated that they also should have performed rounds but has not this week because of the survey.During an interview on 12/09/2025 at 11:33 AM, the Administrator stated all food items should be labeled and dated when received in the kitchen, when prepared or rewrapped for freezing and defrosting. If food items are not, they should be discarded. The Administrator also stated that after the Director of Food Service left the facility, they reviewed kitchen audit tools including the overall pathways from The Center from Medicare and Medicate Services with the dietary supervisor. They asked them to follow the pathways to ensure compliance. The audits were to be used as a guide for food labeling, storage dates, temperatures, food handling and receiving. The Administrator further stated that they met with the dietary supervisor last week and went through their rounding responsibility and that they also perform kitchen rounding for temperatures and storage, but they did not look for details in the walk-in refrigerator including defrosting meats. 10 NYCRR 415.14(h) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>Based on observation, record review, and interviews, the facility failed to 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 Food and Nutrition Services, Administration, Infection Control, Physical Environment, and Training Requirements. Specifically, 1.) The Administration did not monitor and enhance the quality of care and services as indicated by widespread deficiencies and repetition of deficiencies that were cited on previous recertification surveys. 2.) The Nursing Services were not administered adequately to ensure that infection prevention and control practices were maintained, and that Certified Nursing Assistants received the required 12 hours of in-service training. The findings are: 1. Cross refer to F801, F812, F842, F908, and F919The Administration was aware that the facility's licensed dietitian resigned, and the facility needs to employ a qualified dietitian to oversee the food and nutrition services. They were aware that the call system was not functioning as intended on the second floor. The Administrator was unaware that the drug regiment review reports were not readily available. 2. Cross refer to F881 and F947The Director of Nursing was aware of the extent of the infection control issue and was aware that there was no documented evidence that the certified nursing assistants received the required 12-hours of in-service training. On 12/09/2025 at 3:48 PM, the Administrator was interviewed and stated they have an understanding that as a Special Focus Facility, multiple issues need to be resolved, and they believed they made a lot of progress in addressing the problems the facility used to have. They stated that the concerns raised on this recertification survey were not the same issues\ that were found in previous surveys. They stated that they feel they have done a lot better, and that resident care had improved. 10 NYCRR 415.26 |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on observations, record review, and interviews, the facility failed to maintain a comprehensive Quality Assurance and Performance Improvement (QAPI) program and plan with governance and leadership oversight. Specifically, the facility had widespread deficiencies in the areas of Food and Nutrition Services, Administration, Infection Control, Physical Environment, and Training Requirements. In addition, the facility had deficiencies (F656, F711, F801, F812, F835, F865, F880) from previous Recertification surveys that were repeatedly cited in the current survey whereby plans of correction were previously accepted by the New York State Department of Health, but the facility had no documented evidence of implementation or maintenance of outcomes.The findings are:The facility policy and procedure titled Quality Assurance and Performance Improvement Plan last updated on 01/2025 stated that the Quality Assurance and Performance Improvement Committee meets at least monthly and consists of the Administrator, Director of Nursing, Medical Director, department heads, and residents and/or family members as appropriate. The policy documented that data will be collected and reviewed on resident outcomes, satisfaction surveys, staff performance, and compliance trends. 1. For widespread deficiencies, cross reference F801, F812, F835, F842, F881, F908, F919, and F947. 2. For repeated deficiencies, cross reference F656, F711, F801, F806, F812, F835, F865, and F880. During an interview on 12/09/2025 at 3:42 PM, the Medical Director stated that the medical department is working to address infection control issues. During an interview on 12/09/2025 at 3:45 PM, the Administrator stated they were unaware of any infection control problem and that the Quality Assurance and Performance Improvement committee will have to identify who handles the vaccine records. The Administrator stated they would make recommendations to address concerns on antibiotic stewardship. The Administrator stated that since the Registered Dietitian left in September 2025 refrigerators have not been audited, meal trackers are not being updated, and the facility has no Registered Dietitian. The Administrator stated that the potential deficiencies were not the same issues that were raised on previous surveys. 10 NYCRR 415.27(a-c) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Implement a program that monitors antibiotic use.<br><br>Based on observation, record review, and interviews, the facility failed to develop an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This was evident during the Infection Control Task. Specifically, the facility had no system to monitor antibiotic use. There was no system of reports related to antibiotic usage and resistance data. The findings are: The policy and procedure titled Antibiotic Stewardship Program with a reviewed date of 06/2024 documented the facility maintains an active Antibiotic Stewardship Program as part of its Infection Prevention and Control Program. The Infection Preventionist, under the oversight of the Director of Nursing, coordinates the Antibiotic Stewardship Program. The Medical Director and Consultant Pharmacist support the program through clinical guidance and oversight of antibiotic use. The policy documented that the facility monitors antibiotic prescribing patterns and outcomes. A review of Resident #1's medical record showed that Resident #1 had a diagnosis of urinary tract infection. A physician's order dated 12/03/2025 included Macrobid (an antibiotic) 100 milligrams to give one (1) capsule by mouth two (2) times per day for seven (7) days for urinary tract infection. A review of Resident #7's medical record showed a diagnosis of malignant otitis externa (invasive infection of the ear canal). A physician's order dated 12/02/2025 included Augmentin (an antibiotic) 500 milligrams, by mouth, every 12 hours for 10 days. There was no documented evidence that the facility monitors antibiotic usage and resistance data. There was no evidence of staff education on antibiotic stewardship. On 12/08/2025 at 11:43 AM, the Assistant Director of Nursing was interviewed and stated they are also the Infection Preventionist. They stated they started working in the facility in October 2025. They stated they had not been tracking antibiotic use in the facility. On 12/08/2025 at 11:52 AM, the Director of Nursing was interviewed and stated the Infection Preventionist is responsible for managing the Antibiotic Stewardship Program. The Director of Nursing stated they have been overseeing the Antibiotic Stewardship Program since the last Infection Preventionist was terminated in July 2025 until the new Infection Preventionist was hired in October 2025. On 12/08/2025 at 2:34 PM, the Medical Director was interviewed and stated they have not been tracking antibiotic use in the facility since they do not have many infections. They stated that there was a nurse who gives them reports on antibiotic use, but since that nurse resigned they had not received any report. 10 NYCRR 415.19 |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Keep all essential equipment working safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification Survey from 12/01/2025 to 12/09/2025, the facility did not maintain all mechanical, electrical, and patient care equipment in safe operating condition. Specifically, during the observation of the dishwashing task and review of the associated daily temperature logs the mechanical dishwasher was below 150 degrees Fahrenheit on more than one (1) occasion. Review of the Kitchen Equipment invoice dated 11/06/2025 indicated that the mechanical dishwasher has been malfunctioning, and the facility had failed to pay the vendor to have it repaired. The findings are:The facility policy titled Dishwasher and Manual Sanitizing Policy, with revision date 03/2025, documented that the facility will ensure all dishware, utensils, and food-service equipment are safely washed and sanitized at the required temperatures, and that an approved chemical sanitizing method is used whenever the dishwasher or booster heater is not fully operational. The facility uses a commercial dishwasher equipped with a booster heater to achieve proper sanitizing temperatures. Required temperatures per the manufacturer and Department of Health standards are a minimum of 150degrees Fahrenheit during the wash cycle and a minimum temperature of 180degrees Fahrenheit at the final rinse. If required temperatures are achieved, the dishwasher remains the primary sanitizing method. When the booster heater or dishwasher fails to reach the required sanitizing temperatures, stop using the machine immediately, mark machine out of service, and switch to manual three (3) compartment sink sanitizing using an approved chemical sanitizer. The dishwasher can only be returned to service when maintenance repairs are completed, and the machine again reaches all required temperatures.On 12/08/2025 at 10:38 AM, a kitchen observation was performed with the Dietary Supervisor who demonstrated a dish run through the single conveyor dishwasher. The dishwasher temperature was observed at 120 degrees Fahrenheit. Three bottles of sanitizer were observed connected to the dishwasher.A Dishwasher Daily Temperature Log dated December 2025, documented dishwasher wash and rinse temperatures three (3) times a day: breakfast, lunch and dinner. The breakfast wash temperature on 12/05/2025 was documented as 124degrees Fahrenheit. The breakfast wash temperature on 12/08/2025 was documented as 120degrees Fahrenheit.A Kitchen Equipment Invoice dated 11/06/2025 documented a description of the [NAME] Dishwasher at the facility as follows: Booster has leak on tank. Leaking on electrical. Must replace booster which is in extremely poor condition. Should be shut down. Payments or credits toward payment were documented as zero (0).During an interview on 12/08/2025 at 10:43 AM, the Dietary Supervisor stated that since 12/05/2025, the dishwasher had been malfunctioning and not consistently maintaining an adequate washing temperature of 150degrees Fahrenheit. Two (2) additional sanitizing agents have been added for use with the machine until repair is completed. The Dietary Supervisor also stated that a repair company was called and is ordering a replacement booster that is needed to maintain the dishwasher temperatures, but they do not have a replacement date.During an interview on 12/09/2025 at 11:33 AM, the Administrator stated they were informed by the Dietary Supervisor that as of last week, the dishwasher had not been reaching adequate temperatures. A repair company came out and ordered a booster to help increase the temperatures. The Administrator also stated that they do not have any details on when the dishwasher will be repaired as the Dietary Supervisor spoke with the repair person from the company and is waiting for a date of completion. The Administrator further stated that they would follow up on the repair date. No repair date was provided to the surveyor.10 NYCRR 415.29(b) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, record review, and interviews, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents. This was evident for one (1) of 11 residents (Resident #88) reviewed for accidents out of 35 total sampled residents. Specifically, Resident #88 who was identified as at risk for falls, was observed without floor mats and their bed not in the lowest position as stated in their care plan. The findings are:The facility's policy and procedure titled Falls Prevention with a revision date of 05/14/2023 documented that it is the policy of the facility to assess all residents for their fall risk potential and institute an appropriate plan of care designed to prevent/reduce falls. A Fall Risk Assessment Score totaling 21 or more places the resident at risk for falls and therefore a prevention protocol should be initiated immediately. The protocol plan of care is entered onto the resident's care plan. The licensed Nurse will use the established protocols for fall risk prevention as a basis for the resident's plan of care. The nurse will individualize the plan of care to meet the resident's need as appropriate. The facility's policy titled Managing Falls and Fall Risk with a revision date of 07/2025, documented that based on previous evaluations, and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The Interdisciplinary Team will identify appropriate interventions to reduce the risk of falls. If falling recurs despite initial interventions, the interdisciplinary team will implement additional or different interventions or indicate why the current approach remains relevant. The interdisciplinary team will identify and implement relevant interventions (for example bed/chair alarms, wheelchair cushions, perimeter mattress, floor mats) to try to minimize serious consequences of falling. Resident #88 had diagnoses that included schizoaffective disorder (severe mental illness that includes symptoms of both schizophrenia such as hallucinations and delusions) and mood disorders (such as depression or mania), dementia (loss of memory), and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 10/06/2025 documented Resident #88 had severely impaired cognition and had functional limitations in range of motion on both sides of the upper and lower extremities, utilized a manual wheelchair for mobility, was dependent for toileting hygiene, showers/bathing and required partial to moderate assist for sit to stand mobility, transfers and wheelchair locomotion. A care plan for falls was initiated for Resident #88 on 12/06/2016 and was last reviewed on 10/12/2025. The care plan documented Resident #88 was at risk for falls due to intermittent confusion, needs assistant for toilet and transfers, and psychiatric disorders. The facility interventions included to maintain bed position at the lowest level with bilateral floor mats on each side of bed. Further review of the falls care plan revealed that Resident #88 had falls on 05/07/2025 at 7:55 AM, when resident was found sitting on the floor next to their bed; on 09/30/2025 at around 4:00 PM when they were found sitting on the floor mat on the right side of their bed; and on 10/12/2025 when they were found sitting on the floor next to their bed. On 12/01/2025 at 10:35 AM, Resident #88 was observed in their room, sitting in bed with the door closed. The bed was observed at the highest position and there were no floor mats on either side of bed. On 12/01/2025 at 1:34 PM, Resident #88 was observed crawling in bed. The bed was elevated at the highest position. There were no floor mats on either side of bed. On 12/08/2025 at 5:05 PM, an interview was conducted with Certified Nursing Assistant #13, and they stated that Resident #88 was on their assignment. Resident #88's room was observed with Certified Nursing Assistant #13 who stated that there are no floor mats in the resident's room. On 12/09/2025 at 4:00PM, an interview was conducted with the Director of Nursing who stated that Resident #88 had history of multiple falls, is non-compliant, and gets up on their own. The Director of Nursing stated Resident #88 is on half hourly monitoring and that their care plan interventions include placing bed in lowest position and use of floor mats. They stated that the nursing supervisors are responsible for making rounds in the unit and ensuring that floor mats are in use or if the bed is in the lowest position. 10 NYCRR 415.12(h)(2) |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>Based on observations, interviews, and record review, the facility failed to ensure the physician reviewed the resident's total program of care. This was evident for one (1) of 12 residents reviewed (Resident #8). Specifically, there was no documented evidence that a physician evaluated Resident #8 after a fall incident on 07/30/2025. The findings are: There was no documented evidence the facility has a policy related to physician services. Resident #8 was admitted to the facility with diagnoses that included diabetes mellitus (a condition that affects blood sugar levels), hypertension (high blood pressure), and depression. The Minimum Data Set (a resident assessment tool) dated 10/23/2025 documented Resident #8's cognition as intact and was independent in bed mobility, transfers, and toilet use. A nurse's progress note by Registered Nurse #7 dated 07/30/2025 at 10:39 AM documented that Resident #8 was sitting in the day room, asleep on the chair, and fell to the floor. A scant amount of blood was noted on the left nostril which was cleaned; there was no further bleeding was noted. The note documented that Physician #1 was notified. A nurse's progress note by Registered Nurse #1 dated 07/30/2025 at 2:22 PM, documented that Resident #8 was observed on the floor in the day room at 9:00 AM. The resident stated they fell asleep while sitting on the chair. There was a scant amount of blood in the left nostril noted on assessment; there was no visible injury and resident denied pain. The interdisciplinary progress notes from 07/30/2025 through 08/05/2025 had no documented evidence that a physician assessed or evaluated Resident #8 related to their fall on 07/30/2025. On 12/08/2025 at 10:45 AM, Registered Nurse #7 was interviewed and stated they were to called to the unit on 07/30/2025 to assess Resident #8 who slipped to the floor. Registered Nurse #7 stated they noted a small amount of bleeding from Resident #8's nose which they cleaned. They stated there was no further bleeding observed after they cleaned the resident's nose. Registered Nurse #7 stated they notified the physician of the resident's fall. On 12/08/2025 at 10:18 AM, Nurse Practitioner #1 was interviewed and stated they do not recall being notified of Resident #8's fall incident on 07/30/2025. On 12/08/2025 at 12:29 PM, Physician #1 was interviewed and stated they recall Resident #8 having a tooth extraction at that time, but they do not recall if Resident #8 had a fall or if they were notified of the fall. They stated they usually document in the resident records when they evaluate a resident. On 12/09/2025 at 2:03 PM, the Director of Nursing was interviewed and stated licensed nurses must inform the physician of a resident's fall and that the physicians are to evaluate the resident within 24 to 48 hours. On 12/08/2025 at 2:42 PM, the Medical Director was interviewed and stated that after a fall, nurses are to notify the medical provider, and residents must be seen by the medical provider. They stated that the medical providers must document their assessment in a progress note even when there is no injury. 10 NYCRR 415.15(b)(2)(iii) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on observation, record review, and interviews the facility failed to maintain medical records on each resident in accordance with professional standards and practices that are systematically organized and readily accessible. This was evident for five (5) of five (5) residents (Resident #'s 4, 7, 56, 68, and 88) reviewed for unnecessary medications out of 35 total sampled residents. Specifically, the residents' drug regimen review reports were not readily available for review upon request. The findings include:The facility's policy and procedure titled Drug Regimen Review dated 06/2025 documented that Consultant Pharmacist shall perform Medication Regimen Review for each resident at least monthly; upon completion, shall provide written documentation of all recommendations and submit monthly to the facility for attending prescriber or designees to respond. The Facility shall maintain copies of all Drug Regimen Review recommendations along with prescriber responses in an easily retrievable location for presentation to surveyors upon request.On 12/03/2025 between 10:00 AM and 11:00 AM, during review of medical records, copies of drug regimen review reports with prescriber responses for Resident #s 4, 7, 56, 68, and 88 were not readily available for presentation to the State Surveyors upon request. The copies were provided to the State Surveyors on 12/08/2025 at 2:28 PM, over three (3) working days after the request was made. On 12/08/2025 at 12:21 PM, the Pharmacy Consultant was interviewed and stated they conduct monthly medication regimen review and will send an email of the reports along with the recommendations to the Director of Nursing. On 12/08/2025 at 12:05 PM, Registered Nurse #5 was interviewed and stated that drug regimen review reports are given to the Director of Nursing by the Pharmacy Consultant. They stated they do not have access to copies of drug regimen review reports, and they do not know where they are kept. On 12/08/2025 at 12:46 PM, the Assistant Director of Nursing was interviewed and stated they searched for copies of resident drug regimen review reports, but they could not find them. On 12/08/2025 at 3:40 PM, the Director of Nursing was interviewed and stated that the Pharmacy Consultant emails them the reports and recommendations for the monthly Medication Regimen Review. The reports are also emailed to the Administrator and the Medical Director. The Director of Nursing stated reports are kept in a binder in the nursing office, but they were missing the reports for residents that were covered by the Medical Director. The Director of Nursing stated they later found the missing drug regimen review reports in the Medical Director's Office. On 12/08/2025 at 3:45 PM, the Medical Director was interviewed and stated they review the residents' drug regimen review reports and keep a copy of the recommendations in the Medical Director's office. They stated that the facility has high staff turnover, and that new staff have difficulty retrieving the documents for State Surveyor's review in a timely manner. On 12/08/2025 at 4:03 PM, the Administrator was interviewed and stated they print out copies of necessary documents and give them to the Director of Nursing for filing. The Administrator stated they are surprised there are delays in giving the documents to the State Surveyors10 NYCRR 415.22(c) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the Recertification Survey, the facility failed to ensure that each resident was offered the pneumococcal and influenza immunizations. This was observed in five (5) of nine (9) residents (Residents #25, #88, #99, #153, #202) sampled for immunizations out of a total of 38 sampled residents. Specifically, there was no documented evidence that Residents #25, #88, and #202 were offered, educated, received or declined the influenza immunization, and there was no documented evidence that Residents #25, #88, #99, #153, and #202 were offered, educated, or received or declined the pneumococcal immunization.The findings include:The undated facility policy titled Influenza Vaccine, documented that all residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.The undated facility policy titled Pneumococcal Vaccines, documented that all residents will be offered pneumococcal vaccine to aid in preventing pneumonia/pneumococcal infections.Resident #25 was admitted to the facility on [DATE] and had diagnoses including paranoid schizophrenia (a serious mental health condition that affects how people think, feel and behave), cerebral infarction (stroke) and type 2 diabetes mellitus (a group of diseases that affect how the body uses blood sugar). The Quarterly Minimum Data Set (a resident assessment tool) dated 11/12/2025 documented that Resident #25 had intact cognition. It also documented that Resident #25's pneumococcal immunization status was not up to date because it was not offered. The facility was unable to provide documented evidence that Resident #25 was offered and educated on the pneumococcal immunization. The facility was also unable to provide documented evidence that Resident #25 was offered and educated on the influenza immunization.Resident #88 was admitted to the facility on [DATE] and had diagnoses including Diabetes Mellitus (a group of diseases that affect how the body uses blood sugar), Schizophrenia (mental health condition that affects how people think, feel and behave), and Alzheimer's Disease (a condition that affects memory). The Significant Change Minimum Data Set, dated [DATE] documented that Resident #88 had severely impaired cognition. It also documented that Resident #88's pneumococcal immunization status was not up to date because it was not offered. The facility was able to provide documented evidence that Resident #88's representative was offered, educated, and authorized the pneumococcal and influenza immunizations on 10/04/2025 but was unable to provide documented evidence that Resident #88 received the immunizations.Resident #99 was admitted to the facility on [DATE] and had diagnoses including paranoid schizophrenia, dementia (loss of memory), and anemia (low level of red blood cells). The Quarterly Minimum Data Set, dated [DATE] documented that Resident #99 had severely impaired cognition. It also documented that Resident #99's pneumococcal immunization status was not up to date because it was not offered. The facility was able to provide documented evidence that Resident #99's representative was offered and educated on the pneumococcal immunization on 10/06/2025 but the form did not document whether the immunization was authorized or declined. The facility also was unable to provide documented evidence that Resident #99 received the immunization.Resident #153 was admitted to the facility on [DATE] and had diagnoses including bipolar disorder (mental health condition that causes intense shifts in mood, energy levels, thinking patterns and behavior), anemia, and chronic obstructive pulmonary disease (a lung condition that makes it hard to breath). The Discharge Minimum Data Set, dated [DATE] documented that Resident #153 had intact cognition. It also documented that Resident #153's pneumococcal immunization status was not up to date because it was not offered. The facility was unable to provide documented evidence that Resident #153 was offered and educated on the pneumococcal immunization.Resident #202 was admitted to the facility on [DATE] and had diagnoses including cerebellar stroke syndrome (a type of stroke that affects the back of the brain), behavioral disturbance, and dementia. The Quarterly Minimum Data Set, dated [DATE] documented that Resident #202 had severely impaired<br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | cognition. It also documented that Resident #202's pneumococcal immunization status was not up to date because it was offered and declined. The facility was unable to provide documented evidence that Resident #202's pneumococcal immunization was offered, education was provided, and that Resident #202 declined the pneumococcal immunization. The facility was also unable to provide documented evidence that Resident #202 was offered and educated on the Influenza immunization.During an interview on 12/08/2025 at 10:02 AM, the Infection Preventionist who is also the Assistant Director of Nursing stated, the folder containing resident immunizations was deleted from their computer. They had to reach out to the residents or their representatives a second time to obtain authorizations or declinations for the immunizations.During an interview on 12/08/2025 at 11:52 AM, the Director of Nursing stated that the facility offers residents immunizations for COVID-19, influenza, pneumococcal, and respiratory syncytial virus (RSV). The Director of Nursing stated the previous Infection Preventionist was let go at the end of June or the beginning of July of this year and they instructed the current Infection Preventionist to take over the whole operation back in late October. The Director of Nursing was unable to explain why the immunization records were not found in the electronic medical record or the immunization binders.10NYCRR 415.19(a)(4) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the Recertification Survey, the facility failed to ensure that each resident was offered the COVID-19 immunization. This was observed in four (4) of nine (9) residents (Residents #25, #99, #153, #202) sampled for immunizations out of a total of 38 sampled residents. Specifically, there was no documented evidence related to the screening, administration or declination, and education on the COVID-19 immunizations for Residents #25, #99, #153, and #202.The findings include:The facility policy titled Infection Prevention and Control last reviewed 06/2025 documented the COVID-19 vaccine will be offered to all residents upon admission as part of the facility's routine immunization program. Each resident will be screened to determine their vaccination status and clinical eligibility. All screening results, vaccine offerings, consent/refusals, and vaccination administration will be documented.Resident #25 was admitted to the facility on [DATE] and had diagnoses including paranoid schizophrenia (a serious mental health condition that affects how people think, feel and behave), cerebral infarction (stroke) and type 2 diabetes mellitus (a group of diseases that affect how the body uses blood sugar). The Quarterly Minimum Data Set (a resident assessment tool) dated 11/12/2025 documented that Resident #25 had intact cognition. It also documented that Resident #25's COVID-19 immunization status was not up to date. The facility was unable to provide documented evidence that Resident #25 was offered and educated on the COVID-19 immunization.Resident #99 was admitted to the facility on [DATE] and had diagnoses including paranoid schizophrenia, dementia (loss of memory), and anemia (low level of red blood cells). The Quarterly Minimum Data Set, dated [DATE] documented that Resident #99 had severely impaired cognition. It also documented that Resident #99's COVID-19 immunization status was not up to date. The facility was able to provide documented evidence that Resident #99's representative was offered, educated, and authorized the COVID-19 immunization on 10/06/2025 but the form did not document whether the immunization was accepted or declined. The facility was unable to provide documented evidence that Resident #99 received the immunization.Resident #153 was admitted to the facility on [DATE] and had diagnoses including bipolar disorder (mental health condition that causes intense shifts in mood, energy levels, thinking patterns and behavior), anemia, and chronic obstructive pulmonary disease (a lung condition that makes it hard to breath). The Discharge Minimum Data Set, dated [DATE] documented that Resident #153 had intact cognition. It also documented that Resident #153's COVID-19 immunization status was not up to date. The facility was unable to provide documented evidence that Resident #153 was offered and educated on the COVID-19 immunization.Resident #202 was admitted to the facility on [DATE] and had diagnoses including cerebellar stroke syndrome (a type of stroke that affects the back of the brain), behavioral disturbance, and dementia. The Quarterly Minimum Data Set, dated [DATE] documented that Resident #202 had severely impaired cognition. It also documented that Resident #202's COVID-19 immunization status was not up to date. The facility was unable to provide documented evidence that Resident #202 was offered and educated on the COVID-19 immunization.During an interview on 12/08/2025 at 10:02 AM, the Infection Preventionist who is also the Assistant Director of Nursing stated the folder containing resident immunizations was deleted from their computer. They had to reach out to the residents or their representatives a second time in order to obtain authorizations or declinations for the immunizations.During an interview on 12/08/2025 at 11:52 AM, the Director of Nursing stated that the facility offers residents immunizations for COVID-19, influenza, pneumococcal, and respiratory syncytial virus (RSV). The Director of Nursing stated the previous Infection Preventionist was let go at the end of June or the beginning of July of this year and they instructed the current Infection Preventionist to take over the whole operation back in late October.<br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Director of Nursing was unable to explain why the immunization records were not found in the Electronic Medical Record or the Immunization Binders.10 NYCRR 415.19 |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure there was adequate equipment to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. This was evident for 25 out of 25 rooms on the second floor. Specifically, call bell systems did not function as designed and residents were given hand bells. The findings are: The facility's policy and procedure titled Preventative Maintenance Program with a last reviewed date of 01/2025 stated that the Maintenance Director will be responsible for developing and maintaining a schedule of maintenance services to ensure that the building, grounds and equipment are maintained in a safe and operable manner. On 12/02/2025 at 10:16 AM, the call bell system was tested on the second floor. room [ROOM NUMBER]'s call light went on when the bell was pressed but there was no bell sound either in the unit's north corridor or at the nursing station. Resident #19, room [ROOM NUMBER]'s current occupant stated that the facility had given them a hand bell because the call bells were broken. Resident #5, who resides in room [ROOM NUMBER] on the east corridor, confirmed that they also had a hand bell. Resident #5 stated they also press the call bell, because even though the call bell does not make a sound, the light usually attracts staff after some time. On 12/08/2025 at 2:34 PM, the call bells were tested on the second floor. The lights above the doorway will light up but none of the call bells in any room emitted a sound. On 12/08/2025 at 2:58 PM, Resident #11, who resides in room [ROOM NUMBER], was interviewed and stated they were given hand bells because the call bell is broken. On 12/08/2025 at 3:10 PM, Certified Nursing Assistant #2 was interviewed and stated they have been working on the second floor for two (2) years and that the call bells have always been broken. On 12/08/2025 at 2:41 PM, Registered Nurse #2 was interviewed and stated they have been working on the second floor for a year and that the call bells had never been properly working in all rooms on the second floor. Registered Nurse #2 stated that residents were provided hand bells and that residents bring the hand bells with them when they go to the bathroom. On 12/04/2025 at 3:10 PM, the Maintenance Director was interviewed and stated that the call bell system in the entire facility is operational except in the north corridor on the second floor. The Maintenance Director stated that the system is very old and that the contractor responsible for its maintenance called it antiquated and parts to repair the system were very difficult to obtain. The Maintenance Director stated they requested a proposal from the contractor to replace the system and was provided a cost breakdown for various options shortly after they were hired in June 2025, but that they were still waiting to receive them. On 12/09/2025 at 3:54 PM, the Administrator was interviewed and stated some of the parts for the call system are no longer manufactured so they are waiting for a proposal from a contractor to replace the system. The Administrator stated that the contractor came last week to do a walk through and was told that the proposal will be sent later this week. 10 NYCRR 415.29(b) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>Based on observation, record review, and interviews conducted during the Recertification Survey, the facility failed to ensure that certified nurse aides were provided the required 12 hours of in-service training per year. This was evident for five (5) of five (5) Certified Nursing Assistants reviewed for nurse' aide training requirements. Specifically, the facility was unable to provide documented evidence that Certified Nursing Assistants #14, 15, 16, 17, and 18 were provided 12 hours of annual in-service training. The findings are:A facility document titled Employee Education Inservice Policy with a last reviewed date of 06/2025 stated that the facility will maintain an ongoing in-service education program to support staff competency.The Facility-wide Assessment with a last reviewed date of 09/2025 documented nurse aide in-service training must include no less than 12 hours per year.During a record review of personnel files for Certified Nursing Assistants #14, 15, 16, 17, and 18, who were all currently employed by the facility, there was no documented evidence that the above mentioned certified nursing assistants were provided 12 hours of annual in-service training. On 12/08/2025 at 2:23 PM, the Assistant Director of Nursing was interviewed and stated that they were hired in the facility on 06/16/2025 and were made responsible for providing staff education in the facility. They stated they have arranged and provided four (4) hours of in-service trainings to the staff since they started working in the facility. The Assistant Director of Nursing stated that all records of previous staff in-service education were taken by the former Assistant Director of Nursing when they were terminated. On 12/09/2025 at 1:22 PM, the Human Resources Director was interviewed and stated that they do not keep records of staff education. They stated these are kept in the nursing office.On 12/09/2025 at 3:35 PM, the Director of Nursing was interviewed and stated that the previous Assistant Director of Nursing was terminated and took all the paperwork including staff education records due to a grudge against the facility. 10 NYCRR 415.26(d)(8)(iii-iv) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure that the resident was notified of the transfer or discharge, and the reasons for the move, in writing and in a language and manner they understand for one (1) of four (4) residents (Resident #153) reviewed for hospitalization out of a total sample of 35 residents. Specifically, the facility did not complete a notice of discharge or transfer when Resident #153 was transferred to the hospital on [DATE]. The findings are:The policy and procedure titled Transfer and Discharge (including Against Medical Advice) last revised 01/2025, documented that when the facility initiates a transfer or discharge, notice will be provided to the resident and representative in a manner they can understand.Resident #153 was admitted to the facility on [DATE] with diagnoses that include anxiety disorder (a group of mental health conditions characterized by excessive fear, worry, and anxiety that interfere with daily activities), bipolar disorder(a chronic mental illness that causes dramatic shifts in a person's mood, energy, and ability to think clearly) and chronic obstructive pulmonary disease (is a term for lung and airway diseases that restrict your breathing).The Quarterly Minimum Data Set, dated [DATE] documented resident's cognition as intact, uses oxygen and that resident participated in assessment and goal settingReview of the resident's medical record dated 11/21/2025 - 11/30/2025, revealed there was no evidence that a Notice of Transfer or Discharge form was completed and provided to the resident or resident's representative. On 12/09/2025 at 10:30 AM, the Social Worker Director was interviewed and stated that Resident#153 was transferred to the hospital and therefore did not receive any discharge notification because they were just hospitalized . The Social Worker Director further stated that there is no bed hold in the facility, however, if Resident #153 wants to return to the facility, they can, and that the Ombudsman receives the transfer and the discharge notifications on a monthly basis, so they have sent out the notifications to the Ombudsman for the 11/21/2025 transfer of Resident #153. The Social Worker Director also stated that they are not aware of any staff member telling Resident #153 that they cannot come back to the facility.On 12/09/2025 at 2:00 PM, the Director of Nursing was interviewed and stated that it is the responsibility of the social workers to provide the discharge notice upon transfer to the hospital. The Director of Nursing stated that they are not aware if Resident #153 received the notice at the time of their transfer.On 12/09/2025 at 3:30 PM, the Administrator was interviewed and stated that they would have to go back with social services to audit all discharges to ensure that the proper notifications were made to residents as well as ombudsman notifications. The Administrator stated that they don't have bed hold so they believe we give the notices on transfers.10NYCRR 415.3(i)(1)(iii) (a-c) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observation, record review, and interviews, the facility failed to ensure that a comprehensive person-centered care plan was developed and implemented for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. This was evident for one (1) (Resident #142) of one (1) resident reviewed for transmission-based precautions in the Infection Control task out of 38 total sampled residents. Specifically, Resident #142 who had diagnoses of Osteomyelitis (infection in a bone) and Methicillin-Resistant Staphylococcus Aureus (a type of infection resistant to several antibiotics) had no care plan to address infection and contact precaution. The findings are: The facility policy and procedure titled Comprehensive Care Plans with a reviewed date of 09/2022 documented it is 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.Resident #142 was admitted to the facility with diagnoses including Osteomyelitis of Vertebrae and Methicillin-Resistant Staphylococcus Aureus.The admission Minimum Data Set assessment (a resident assessment tool) dated 11/11/2025 documented Resident #142's cognition was intact.The Physician Order initiated 11/06/2025 and renewed 12/04/2025 documented Contact Isolation for Bacteremia/Methicillin-Resistant Staphylococcus Aureus (MRSA).The nurse's progress note dated 11/18/2025 documented that contact precautions for Resident #142 was maintained due to Methicillin-Resistant Staphylococcus Aureus/ Bacteremia.There was no documented evidence that a comprehensive care plan related to Contact Precautions, Methicillin-Resistant Staphylococcus Aureus, and Osteomyelitis was developed and implemented. On 12/05/2025 at 10:20 AM, Registered Nurse #7 who is the Nursing Supervisor was interviewed and stated Resident #142 had no care plan developed for contact precautions related to infections. Registered Nurse #7 stated the care plans should have been created upon admission and that either the Minimum Data Set Coordinator or Nursing supervisor is responsible for initiating the care plans. On 12/05/2025 at 2:50 PM, the Minimum Data Set Coordinator was interviewed and stated nursing supervisors review the physician admission and readmission orders and initiate the appropriate care plans. The Minimum Data Set Coordinator stated they sometimes add a care plan when completing a resident's assessment if missing. They stated they did not realize Resident #142 had no care plan for infections and contact precautions. On 12/08/2025 at 11:52 AM, the Director of Nursing was interviewed and stated the Nursing Supervisor is responsible for initiating care plans on new admissions. The Director of Nursing stated that everything that was coded in the Minimum Data Set for the admission assessment must have a corresponding care plan. 10 NYCRR 415.11(c)(1) |

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|---|---|---|---|
| | 335744 | A. Building<br>B. Wing | 12/09/2025 |

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

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>Based on observations, record review, and staff interviews, the facility failed to ensure that residents are provided food that accommodates their allergies, intolerances, and preferences. This was evident for one (1) out of 38 residents (Resident #35) reviewed for food preferences. Specifically, during observation on 12/01/2025, Resident #35 who preferred chicken and fish during meals, and disliked beef and pork, was noted with pork in their lunch tray. The findings are: The facility policy and procedure titled Food Preference dated 07/2022, last revised 06/2025, documented: The facility recognizes each resident's right to reasonable food choices and preferences, including cultural, religious, and personal preferences. Resident preferences should be honored to the extent possible while following physician and diet orders, allergy restrictions, and safety requirements. Resident #35 was admitted with diagnoses that included bipolar disorder (a mental health condition that causes extreme mood swings), asthma (a condition that causes your airways to swell, narrow and fill with mucus), chronic obstructive pulmonary disease (lung and airway diseases that restrict your breathing). The Quarterly Minimum Data Set (a resident assessment tool) dated 09/18/2025 documented that Resident #35 had intact cognitive status with a Brief Interview for Mental Status score of 15, Resident #35 is independent of staff for eating - resident completes the activity by themself with no assistance from a helper and Resident #35 is the primary respondent for Daily and Activity Preferences. The Comprehensive Care Plan for Nutritional Status dated 06/21/2025 documented that Resident #35 is on a regular diet/regular consistency with thin liquids. The care plan goals included: Resident will maintain weight without significant weight change and to meet resident's food preferences within diet guidelines. The interventions included: Resident dislikes Beef and Pork, prefers Chicken and Fish. Requested 2x portions of entree, no veal, eggplant, raisin bran cereal, oatmeal, and hard-boiled eggs; Meet food preferences within diet guidelines; Provide diet as ordered: (Regular); Observe meal intake. On 12/01/2025 at 11:19 AM, Resident #35 was observed in their room and interviewed. Resident #35 stated that most of the time, they are not served what is on the meal ticket and that the meal ticket was different from what they get 99% of the time. Resident #35 stated that they do not like pork or beef, but the facility keeps serving them those items. Resident #35 also stated that when they complain to kitchen staff, they are told they serve what they have. On 12/01/2025 at 12:25 PM during meal observation, Resident #35's lunch tray was noted with pork and the resident's ticket documented No Beef or Pork. Resident #35 stated that they requested an alternate item that is not pork, but they were told that they would be given whatever they have in the kitchen. Resident #35 stated: This is what they do all the time. On 12/01/2025 at 12:27 PM, Dietician #2 was interviewed and stated that the tray is served and sent up from the kitchen and cannot explain what happened to Resident #35's tray. Dietician #2 stated that they have no control of what is served from the kitchen, but they will call the kitchen staff to send Resident #35's choice. Dietician #2 further stated that residents' trays are expected to be checked on the tray line to ensure that a resident gets their right choice of food as documented on the ticket. On 12/01/2025 at 12:38 PM, an interview was conducted with Certified Nursing Assistant #1. Certified Nursing Assistant #1 stated that Resident #35's meal ticket indicated No Pork but the resident would sometimes be served beef or pork. The Certified Nursing Assistant stated they cannot recognize pork meat, but if they served Resident #35's tray and the resident complained they are served pork, they would call the kitchen to send alternate food for the resident. On 12/01/2025 at 12:51 PM, Registered Nurse #1 was interviewed and stated that residents' trays are prepared from the kitchen and sent up to the unit with their corresponding tickets. The nursing staff will check and distribute the trays to the residents. Registered Nurse #1 stated that they don't normally check residents' trays when certified nursing assistants are distributing them to the residents. If a resident checks their plate and noticed any items they did not like or that is not to be given to them, they will call the kitchen to send what<br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident requested. Registered Nurse #1 stated that the staff on the unit would distribute the trays to the resident with the ticket placed on the tray, the kitchen staff is responsible for checking and serving the correct menu to the residents as per residents' choice as documented on their ticket. Registered Nurse #1 was unable to explain if Resident #35 is always served beef or pork. On 12/05/2025 at 11:05 AM, Registered Nurse #3 was interviewed and stated that they usually check residents' tickets and order when they are on the units during meals, and they sometimes notice that the kitchen makes mistake of serving residents wrong items on their tray. Registered Nurse #3 stated that if any resident is not served the correct menu item(s), the kitchen is called to send the right food. On 12/05/2025 at 11:07 AM, the Director of Social Services was interviewed and stated that Resident #35 has reported to them that they are not being served their food preferences, and this has been addressed and resolved with kitchen staff in the past. The Director of Social Services stated that they were not aware that dietary is still serving Resident #35 food that is not their preference. On 12/05/2025 at 11:12 AM, the Dietary Supervisor was interviewed and stated that they used to be on the line to ensure that residents' tickets matched the food served on the tray, but right now they only do a spot check, the loader is now checking to ensure that the tickets match with the food served on the tray. The Dietary Supervisor stated that they have been responsible for the role of Food Service Director/Registered Dietician since October 2025 as the previous person is no longer with the facility, and they have not been able to have effective supervision on the line during meal service. The Dietary Supervisor stated that Resident #35 receiving items that did not match the meal ticket must have been due to staff not properly checking that residents' tray menu matches what is on the ticket. The Dietary Supervisor stated that they are trying their best to serve Resident #35, and other residents, their food choices. The Dietary Supervisor stated that they could not explain why the loader could not capture that Resident #35 should not be served pork. On 12/05/2025 at 3:05 PM, the Administrator was interviewed and stated that they currently do not have a Food Service Director. They stated that the previous Food Service Director would enter the residents' food preferences on the meal ticket and would ensure that what's on the meal ticket is what's served on the meal tray. The Administrator stated that with the absence of a Food Service Director, the Dietary Supervisor can audit the residents' meal trays and ensure that the food on the meal tray is what's listed on the meal ticket. On 12/09/2025 at 2:31 PM, the Director of Nursing was interviewed and stated that dietary staff is expected to ensure that a resident is served what is on the resident's meal ticket, and the nursing staff on the unit should be checking to ensure that residents' trays contain what is on the residents' tickets when giving out the trays. The Director of Nursing further stated that they were not aware that Resident #35 is being served food that is not their preference. 10 NYCRR 415.14(d)(4). |

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| Grand Manor Nursing & Rehabilitation Center | 700 White Plains Road<br>Bronx, NY 10473 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review, and interviews, the facility failed to ensure infection control practices and procedures were maintained. This was evident for one (1) unit (six (6) of five (5) resident units. Specifically, Certified Nursing Assistant #5 picked up Resident #152's pillow from the floor and placed it under Resident #152's head without changing the pillowcase.The findings are:The facility policy titled Linen Handling and Infection Control reviewed 12/2024 documented the purpose is to establish safe and sanitary procedures for handling clean and soiled linens and resident clothing in order to prevent the spread of infection within the facility, including residents on contact precautions and those with blood, body fluids, or wound drainage on linens.In an observation on 12/01/2025 at 10:07 AM, Resident #152 was in their reclining wheelchair in the hallway with a pillow on the floor adjacent to them. Certified Nursing Assistant #5 picked up the pillow from the floor and placed it under Resident #152's head without changing the pillowcase.During an interview on 12/01/2025 at 10:09 AM, Certified Nursing Assistant #5 stated they were supposed to change the pillowcase before they placed it under Resident #152's head. They gave Resident #152 their pillow right away because they wanted it. Certified Nursing Assistant #5 stated they made a mistake.During an interview on 12/05/2025 at 10:05 AM, Licensed Practical Nurse #1 stated Certified Nursing Assistant #5 was supposed to change the pillowcase because the floor is dirty. Nursing staff receives in-services on infection control yearly and in-between as well. Licensed Practical Nurse #1 stated the unit nurse and supervisor monitor the certified nursing assistants to ensure they are following infection control protocols.During an interview on 12/08/2025 at 11:52 AM, the Director of Nursing stated the certified nursing assistants should know they have to change the pillowcase when a pillow falls on the floor. They receive in-services annually and as needed when there is an infection related condition on the floor, and this includes handling of linens.10NYCRR 415.19(b) |

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| F 0577<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on interviews, observations and record reviews and interviews, the facility failed to ensure that residents had the right to examine the results of the most recent survey conducted by state surveyors or post them in a place readily accessible to residents and family members. Specifically, on 12/02/2025, resident interviews at the Resident Council Meeting and subsequent observations confirmed that the facility failed to ensure survey results were readily accessible to residents and the public.The findings are:The facility's policy and procedure entitled Survey Results with a documented review date of 06/2025, stated that the facility will post the most recent standard (annual) survey results and any subsequent complaint survey results in an area available to residents, families, visitors and surveyors.During the resident council meeting held on 12/02/2025 at 10:10 AM, 11 residents who were in attendance stated that they do not have access to the survey results. Resident #35 stated that the facility has posted signage noting the location of where the results can be found. However, at the location there is bin where the results are supposed to be held, and it is always empty. Multiple observations conducted on 12/01/2025 and 12/02/2025 confirmed that signage was posted on the left side of the lobby elevator area that indicated where the results could be found. Observations on 12/01/2025 and 12/02/2025 at the location (hallway lobby near the elevator) confirmed that that the survey results were not in the bin or anywhere else at the location.On 12/02/2025 at 12:30 PM, the Director of Nursing gave the surveyor a white binder containing only the results of a complaint survey conducted on 05/29/2025.On 12/05/2025 at 1:57 PM, the Director of Nursing was interviewed and stated, We can't keep the results in the binder because residents take them and tear them up.On 12/05/2025 at 2:41 PM, the Administrator was interviewed and stated that they always keep the surveys in the binder in the bin and place them there themself, but that they do not personally check to see if they remain in place. The Administrator stated they knew they had to have three (3) years of survey results available, and the binder is where they should be maintained. When shown the empty binder as it was observed in the bin, the Administrator stated they did not know why the results were not in the binder. 10NYCRR 415.3(d)(1)(v) |

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| F 0838<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.<br><br>Based on interviews, observations and record reviews, the facility failed to ensure that the Facility-wide Assessment included the services provided. Specifically, the Facility Assessment continued to list Hospice as a service provided by the facility. However, an interview with the Administrator confirmed that the facility had terminated their contract with a certified hospice provider in 2021.The findings are:The facility's Facility Assessment, last reviewed 09/2025, states that the Facility Assessment will be completed annually and will be updated when a significant change occurs. The tool further stated that the Facility Assessment will document resources and services needed to meet resident needs.During an interview on 12/01/2025 at 1:40 PM, a family member of Resident #88 stated that Resident# 88 was admitted to the facility for Hospice Care (comfort care provided with an end-of-life diagnosis). They stated that the hospital discharge planner and the facility's website documented that the facility provided Hospice Care. However, upon admission, they found that hospice was not an offered service and only Palliative Care (comfort care offered at any time of life or illness) was provided.The current Facility Assessment last reviewed 09/2025 listed Hospice Care as a Special Treatment and Condition but noted that 0 residents were on hospice.During an interview on 12/09/2025 at 3:40 PM, the Director of Nursing confirmed that the facility had no hospice contract and offers palliative care but not hospice care services.During an interview on 12/09/2025 at 3:42 PM the Administrator stated that the facility terminated its hospice contract in 2021 and that continuing to list it as an offered service was an oversight. 10 NYCRR 415.26 |