

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Northern Manhattan Rehabilitation and Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 116 East 125th St New York, NY 10035	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, during the Recertification and Complaint (Intake 622067) Survey, the facility failed to notify a resident's representative of a significant change in the resident's status. This was evident for one (1) (Resident #43) of 40 sampled residents. Specifically, Resident #43's representative was not notified of the resident's change in condition that resulted to a hospital transfer on 10/17/2024. The findings include: The facility's policy and procedure titled Notification of Change with a last revised date of March 2024 documented that it was the policy of the facility to document any changes in the resident's condition and inform the medical doctor and designated representative. The facility must inform the resident representative when there is significant change in the resident's physical, mental or psychological status and a decision to transfer a resident. Resident #43 was admitted to the facility with diagnoses that included Hypertension, Depression, and Dementia. The Minimum Data Set assessment dated [DATE] documented Resident #43's cognition as moderately impaired. On 09/15/2025 at 9:07 AM, Resident #43's Health Care Proxy was interviewed and stated that Resident #43 was hospitalized last year but the facility staff did not notify them. The Resident Transfer Form dated 10/10/2024 documented that Resident #43 remained difficult to arouse for 20 minutes. Emergency Medical Service was called. At the time of transfer, the resident was more responsive but sluggish. A review of Resident #43's progress notes from 10/10/2024 to 10/16/2024 had no documentation of Resident #43's change in condition and that Resident #43's family representative was notified of the hospital transfer. The Hospital Discharge summary dated [DATE] documented that Resident #43 was admitted on [DATE] and was discharged on 10/17/2024. On 09/18/2025 at 11:48 AM, Registered Nurse #1, who was the nursing supervisor, was interviewed and stated that Resident #43 had a change in condition and was sent to the hospital and was readmitted to the facility on [DATE]. Registered Nurse #1 stated they called the resident's family to let them know that Resident #43 had returned to the facility. According to Registered Nurse #1, the family was upset because they were not informed that the resident was sent to the hospital. On 09/18/2025 at 12:00 PM, the Assistant Director of Nursing was interviewed and stated that the physician and the family must be notified of a change in a resident's condition. The Assistant Director of Nursing stated that on 10/10/2024, they assessed Resident #43 after they were informed by the unit nurse of the resident's change in condition. They stated that Resident #43 was not responding so they called the physician and the emergency medical service. The Assistant Director stated Resident #43 was transferred to the hospital and that they asked the unit nurse to contact the family. On 09/19/2025 at 9:17 AM, the Director of Nursing was interviewed and stated that the family members must be immediately notified when there is a change in resident's condition. They stated that Registered Nurse #1 called Resident #43's family to inform them that the resident returned to the facility from the hospital and that the family was upset because they were unaware that the resident was hospitalized. 10 NYCRR 415.3(f)(2)(ii)(d)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide a summary of the baseline care plan for two (2) (Residents #5 and #98) of 40 sampled residents. Specifically, Resident #98 and Resident #5's representative were not provided with a written summary of the residents' baseline care plan. The findings include: The facility policy titled Baseline Care Plan with a last revised date of March 2025 documented that it is the policy of the facility to develop baseline care plan within 48 hours of admission. Along with the baseline care plan is a summary of care plan that is provided to the resident and or representative in a language that can be understood. 1. Resident #98 was admitted with diagnoses that included Heart Failure and Peripheral Vascular Disease. The admission Minimum Data Set assessment dated [DATE] documented Resident #98's cognition as intact and that the resident participated in the assessment. On 09/15/2025 at 9:51 AM, Resident #98 was interviewed and stated they received a copy of their medication list but did not receive a written summary of their baseline care plan. Resident #98's baseline care plan was initiated on 05/19/2025 and was completed on 05/21/2025. There was no documented evidence that the summary was given to the resident or their representative. 2. Resident #5 was admitted to the facility with diagnoses that included Cerebrovascular Accident and Heart Failure. The admission Minimum Data Set assessment dated [DATE] documented Resident #5's cognition as moderately impaired and that Resident #5's family representative participated in the assessment. Resident #5's baseline care plan was initiated on 08/08/2025 and was completed on 08/10/2025. There was no documented evidence that the summary was given to the resident's representative. On 09/15/2025 at 11:00 AM, Resident #5's representative was interviewed and stated they have not received a written summary of Resident #5's baseline care plan. On 09/18/2025 at 11:20 AM, Social Worker #2 was interviewed and stated that the resident's baseline care plan is completed 48 hours from admission. They stated they do not provide a written summary of the baseline care plan to the resident, and that it is the Minimum Data Set nurse who is responsible for giving the resident or their representative a written copy of the baseline care plan. On 09/18/2025 at 11:30 AM, the Minimum Data Set Assessor was interviewed and stated that the baseline care plan is completed within 48 hours of admission and is given to the resident along with the medication list. The Assessor stated they do not remember giving the residents or their representative a copy of their baseline care plan. On 09/19/2025 at 10:29 AM, the Minimum Data Set Coordinator was interviewed and stated that the Minimum Data Set nurse is responsible for issuing the baseline care plan to the residents and must document when it was issued. They stated they are responsible for ensuring that the Baseline Care Plan is issued and documented. On 09/19/2025 at 9:30 AM, the Director of Nursing was interviewed and stated that the baseline care plan is supposed to be completed within 48 hours. They stated it is discussed with the resident, a copy given to the resident, and that the resident must sign indicating they received the summary of the baseline care plan. If the resident is not alert, a summary is given to the family, and the family must also sign that they received the copy. The Director stated that if the resident's family cannot come to the facility, then a copy of the baseline care plan is mailed and must be documented in the resident's progress notes. They stated the Minimum Data Set Nurse is responsible for providing the resident and / or their representative of the summary of the baseline care plan. 10 NYCRR 415.11(c)</p>		