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	08/03/2022

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349 Based on observation, interview and record review during the Recertification and Complaint (NY00292383) survey from July 21, 2022, to August 3,2022, the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours, to the New York State Department of Health (NYSDOH) for 3 (Resident #s 42, 121,and 28) of 7 residents reviewed for Abuse out of a total sample of 47 residents. Specifically, the facility did not report an incident of alleged resident-to-resident physical abuse (NY00292383), involving Residents #42 and #121, to the NYSDOH within 2 hours. The facility did not report an alleged incident of resident-to-resident abuse involving Resident #28 to NYSDOH. The findings include: A facility policy titled Accident/Incident Resident dated reviewed or revised May 20,2017, states the purpose of to provide immediate assessment and emergency medical intervention. To provide data for the investigation of accidents/incidents in order to promote a safe environment. To ensure all accidents/ incidents are reported and correct action has been taken. A facility policy titled Accident/Incident dated May 20, 2017, states It is the policy of Grand Manor Nursing & Rehabilitation Center that resident incident/accidents occurring on premises, along with injuries to residents of unknown origin, must be investigated and reported in a timely fashion. The procedure includes the completion of the investigation within 3 days. The DNS is then to review and log in a tracking record. The Medical Director and Administrator are to review and sign off all accident and incident reports. 1) Resident #42 had diagnoses of Major depressive disorder, Schizophrenia, and bipolar disorder without psychotic disorder. An admission Minimum Data Set 3.0 (MDS) dated [DATE] documented Resident #42 had intact cognition and no behaviors. The resident required limited assistance of on person for bed mobility, transfer, and locomotion on unit. Resident #121 had diagnoses of Opioid dependence, anxiety disorder, and major depressive disorder. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission MDS dated [DATE] documented Resident #121 had intact cognition and no behaviors. Resident #121 required extensive assistance of 2 for bed mobility, transfer, and total assistance of 1 for locomotion on unit. An Accident/Incident report dated 3/5/2022 documented at 6 PM, Resident #42 and Resident #121 had a verbal altercation that led to a sudden physical altercation. Resident #42 was noted with a superficial pinpoint sized cut with scant amount of bleeding. Resident #42 refused hospitalization . Resident #121 did not sustain any injuries. The undated investigation summary documented there was cause to believe alleged abuse, mistreatment or neglect occurred. The NYSDOH ACTS system for intake number NY00292383 documented the facility reported the incident on 3/10/2022 at 09:17 AM. This allegation of resident-to-resident abuse was not reported within 2 hours. 2) Resident #76, the Aggressor, had diagnoses of Dementia and Schizophrenia. An admission MDS dated [DATE] documented Resident #76 had severely impaired cognition. Resident #76 exhibited physical and verbal behaviors toward others, other behaviors not directed towards others, rejection of care, and wandering behaviors for 1 to 3 days of the assessment period. Resident #76 required supervision with set-up for bed mobility and transfer. Resident #28, the victim, had diagnoses of Alzheimer's disease, Psychotic disorder with delusions, and undifferentiated Schizophrenia. A Quarterly MDS dated [DATE] documented Resident #28 had severely impaired cognition and no behaviors. Resident #28 required extensive assist of 1 for bed mobility, limited assist of 1 for transfer, and supervision set-up assistance to walk in room/corridor. Resident #28 had a Wander/elopement alarm. An Accident/Incident report dated 3/22/2022 documented Resident #76 was the aggressor and punched/pushed Resident #28 to the floor. A nursing note from Resident #76's medical record written on 3/22/2022 @ 3:02 pm resident #76 attacked resident #28 and pushed them to the floor in the day room. Supervisor made aware. Staff intervened to de-escalate the situation. Resident was assisted to their room. A Nursing note dated 3/22/22 documented Resident #76 was very aggressive and physically trying to abuse other resident and Staff. Resident trying to attack staff and residents for no reason and unprovoked. They were transferred to ER for further evaluation. A Nursing Note written on 3/23/2022 at 1:04 PM documented on 3/22/22 at approximately 3pm the writer was notified that Resident #28 was pushed by another resident. Resident #28 was immediately separated from the aggressor, the supervisor was called, and Resident #28 was assisted back to the chair. No signs of bruising noted. The RN supervisor and physician were made aware. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Note written on 3/23/22 by the Registered Nurse Supervisor (RNS #3) documented on 3/22/22 at around 3pm writer was notified Resident #28, who was alert and oriented X 1, was approached by another resident and pushed on the floor. Staff immediately intervened and separated both residents. Upon RNS #3's arrival, Resident #28 was on the floor. Resident #28 was assisted back to the chair, and he/she was not in distress and denied pain. The physician was informed, and the aggressor sent to the ED for psych evaluation. Next of kin informed. This incident was not reported to NYSDOH. On 7/29/22 at 6:34 PM and 8/1/22 at 3:51 PM, an interview was conducted with the Director of Nursing Services (DNS). The DNS stated Resident #76 was confused, and their actions were not intentional. The occurrence on 3/22/2022 was done for no reason without any provocation. The DNS stated he/she is responsible for reporting to NYSDOH, and allegations of abuse should be reported within 2 hours. The failure to report the incident was an oversight. 415.4(b)2 46035

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on record review and interviews during the extended Recertification and Complaint survey (NY00293005), the facility did not ensure that an investigation was completed for a resident with an injury of unknown origin for 1 (Resident #26) of 12 residents reviewed for Accident. Specifically, an investigation was not initiated when Resident #26 was found with a bruised nose of unknown origin to rule out abuse, neglect, or mistreatment. The finding is: The Policy and Procedure (P&P) titled Accident/Incident revised 5/20/17 documented that resident incident/accidents occurring on premises, along with injuries to residents of unknown origin, must be investigated and reported in a timely fashion. Resident #26 was admitted to the facility on [DATE] for emergency placement and diagnosis included schizophrenia, developmental delay, and autism. The Quarterly Minimum Data Set (MDS) 2/7/22 documented Resident #26 had severely impaired cognition. The MDS documented that resident required the extensive assist of one person for bed mobility, transfer, dressing, eating and personal hygiene. The resident required the extensive assist of two persons for toilet use. On 7/25/22 at 9:03 AM, the Complainant was interviewed via phone. The Complainant stated that Resident #26 was observed with bruised nose, and nursing staff was not able to explain the bruise. The Comprehensive Care Plan (CCP) titled Peer Abuse Prevention created 11/1/21, revised 7/18/22. Interventions included to allow resident to vent feelings, anticipate needs, family involvement, hospitalization as needed, medication per MD order, protect from over stimulation, psychiatry consult, redirect/refocus attention by offering alternative activities, and use stop sign at doorway. The CCP titled Accident/Incident/Injury created 4/21/22, revised 6/24/22. Interventions included to maintain adequate lighting, clutter free environment, keep bed in lowest position, keep call bell within reach, wears helmet at all times when out of bed and removes only at bedtime. The CCP titled Victimize/Victimization created 5/11/22, revised 7/25/22. Interventions included to use calm approach, talk in a soothing manner, identify triggers for behavior, keep separate from other residents possibly disturbed by the behaviors exhibited whenever possible, encourage family/friends involvement, observe for peer's wandering behaviors and redirect, provide calming activities, redirect as needed, and utilize stop sign on doorway as needed. The Nursing Note dated 11/12/21 documented Resident #26 was noted with a dark area on nose. Management was made aware, and the concern was documented in MD/NP communication book for follow up. The Physician Note dated 11/15/21 documented Resident #26 was seen and noted with yellow discoloration about 1 cm of diameter on resident's nasal bridge. X rays of nasal bones and head were ordered. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Orders dated 11/15/21 documented STAT order of facial and nasal bones The X Ray Reports dated 11/15/21 documented results showed no evidence of displaced fracture or dislocation of the nasal and facial bones. The Social Service note dated 11/15/21 documented resident's family was made aware of the bruise on the resident's nose. There was no documented evidence in the medical record that the resident had any accidents or falls from 10/29/21 to 11/12/21. There was no documented evidence that facility investigated Resident #26's injury to rule out abuse, neglect or mistreatment. On 08/02/22 at 11:44 AM, the Licensed Practical Nurse (LPN #1) was interviewed. LPN #1 stated that she does not remember the resident having a bruised nose. LPN #1 stated that when a resident is observed with an unknown injury, the RN Supervisor will evaluate the injury and notify the physician for treatment. An Accident/Incident (A/I) Investigation is completed and submitted to DON for review. LPN #1 does not know why A/I was not completed, but it should have been initiated. On 08/02/22 at 12:00 PM, the Director of Nursing (DON) was interviewed. The DON stated that there was no Accident/Incident report completed for this incident. The nurse who documented the dark area observed on Resident's #26's nose, did not notify the RN Supervisor. The DON stated he/she could not recall this event because it was not investigated nor reported to her. The DON stated the injury should have been investigated. 415.4(b)(3)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observations, interviews, and record reviews conducted during the Recertification and Extended Survey, the facility did not ensure that comprehensive person-centered care plans were developed and implemented for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment for 6 (Resident #s 6, 33, 48, 82, 85 and 196) of 46 sampled residents. Specifically, Resident #82 had no comprehensive care plan (CCP) developed to address dialysis, and unsafe smoking. Resident #48, #33 and 196 had no CCP to address smoking and unsafe smoking. Resident #6 had no CCP developed to address dialysis. Resident #85 had no CCP developed to address psychotropic medication. The findings included but are not limited to: Review of a facility policy, Comprehensive Care Plans dated 01/01/21 documented that Comprehensive Care Plan (CCP) will be developed for each resident that will include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments. The policy also stated that the CCP will be completed within 7 days after the completion of comprehensive assessments. It will be prepared by the interdisciplinary team and be periodically reviewed and revised by the team. 1) Resident #82 was admitted to the facility with diagnoses which include End Stage Renal Disease (ESRD) on Hemodialysis, Diabetes, and Anemia. The Quarterly Minimum Data Set 3.0 (MDS) assessment, dated 05/29/22, documented Resident #82 had intact cognition. The MDS further documented the resident received Hemodialysis while a resident. The resident required limited assistance for transfer, toileting, and ambulation, and extensive assistance for personal hygiene. The Physician's order dated 5/26/22, renewed 7/21/22, documented orders for Hemodialysis on Tuesdays, Thursdays, and Saturdays at 6pm. A Nursing Note dated 07/09/22 documented that the resident refused dialysis today. A Nursing Note dated 07/01/22 documented Resident #82 returned from AV fistula appointment for Left upper Arm AV Graft. A-V access is ready for hemodialysis. Resident is to return to the clinic on 7/26/22 by 7.00am for catheter removal. There was no documented evidence a CCP for hemodialysis was developed. Initial Social Service Assessment and Psychosocial History dated 05/28/21 documented that the resident admitted to smoking cigarettes and alcohol use. Social Service Assessment and Psychosocial notes dated 01/19/22 and 05/26/22 documented Resident #82 admitted to smoking cigarettes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Social Worker behavioral note dated 07/18/22, documented that nursing staff observed resident with noncompliance behavior. Resident noted smoking in the facility despite being counseled on the facility's current smoking rules. There was no documented evidence a CCP was developed to address the resident's smoking status and unsafe smoking. On 07/29/22 at 11:29 AM, the Registered Nurse (RN#1) stated he/she is responsible for developing the CCP, and there should be a Hemodialysis CCP. RN #1 stated the facility had been going through some staffing issues lately, and they have to pass medications, follow up on appointments, and f/u on all other resident care. On 07/29/22 at 11:07 AM, an interview conducted with the MDS Coordinator (MDSC). The MDSC stated they make the weekly schedule list of the residents due for care plans. The list is sent to all departments so each discipline will be able to review and revise the resident's care areas prior to the CCP meeting. The MDSC stated he/she ensures the care plans are done and revised timely. The RN Supervisor is responsible to update care plans related to new admissions and revision of care plans. The facility has 3 RN supervisors and 1 LPN on each unit during the day, making it difficult for the nurses to complete the required work, like care planning. The MDSC stated there is a shortage of nurses, and the agencies used are unreliable as their staff do not stay long. 2) Resident # 196 was admitted with diagnoses which include, Seizure Disorder, Coronary Artery Disease (CAD, Peripheral Vascular Disease (PVD), Schizophrenia. The most recent annual Minimum Data Set 3.0 (MDS) assessment 06/30/22 documented that the resident cognitive status was moderately impaired (BIM 12). The MDS also documented that the resident required a limited assistance with mobility, transfer and toilet use, and an extensive assistance with personal hygiene. On 7/26/22 at 12:25 PM, Resident #196 was observed coming out of the South stairwell and the alarm sounded and was silenced by the resident. Staff did not respond to the alarm. A Social Worker note (SW) Note dated 07/26/22, documented Resident #196 was observed smoking Marijuana in their room. Resident #196 was educated about the smoking policy, informed the facility is non-smoking, and offered a nicotine patch and gum. The SW also documented that the ethics committee will meet, and a 30-day discharge notice will be provided when a placement is found. The SW admission note dated 06/16/21 documented that resident #196 reported that they smoke, and the SW informed resident about the smoking policy and would be assessed for smoking. A review of a Social Work (SW) note dated 05/13/22 documented the fire alarm sounded in the resident #196's room. The room smelled of cigarette smoke, a room search was done, and a cigarette box and ashes were found. Resident #196 was reminded the facility is smoke-free, and Resident #196 The Fire Alarm Record documented the fire alarm was triggered in Resident #196's room due to cigarette smoking on 03/18/22, 05/1/22, and 06/1/22. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was no documented evidence in the medical record that a smoking care plan was developed to address the resident's smoking status and episodes of unsafe smoking. 3) Resident #85 was admitted to the facility with anxiety disorder, chronic obstructive pulmonary disease, and depressive disorder. The Annual Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #85 had intact cognition. Resident #85 had active diagnosis of non-Alzheimer's dementia, anxiety disorder, and depression, and he/she received 4 days of antipsychotic medication during the look back period. The current Physician's Orders, renewed 7/31/22, documented orders for Risperdal (antipsychotic) 0.5 milligrams (mg) once daily at bedtime for schizoaffective disorder (initiated 6/8/22) and Trazodone (antidepressant) 100 mg once daily at bedtime for major depressive disorder (initiated 11/8/21). The Medication Administration Record dated 6/1/22 through 7/31/22 documented Resident #85 received Risperdal 0.5 mg once daily and Trazodone 100 mg once daily. The Psychiatry Consult Note dated 6/7/22 documented resident with anxiety, depressive and bipolar disorder, was seen for evaluation. No psychotic symptoms were noted, no reported increase in severity of hypomania. It further documented that Resident #85 is stable and recommended to decrease Risperdal 1 mg q HS to Risperdal 0.5 mg q HS. Resident to be monitor for increased psychosis or poor impulse control. There was no documented evidence a CCP for psychotropic medication use was developed for Resident #85. During an interview on 8/1/22 at 09:48 AM, Registered Nurse Supervisor (RNS #4) stated that Resident #85 does not have a CCP developed for psychotropic medication use. RNS #4 stated Resident #85 should have a CCP for pscyhotropic medication because he/she receives antipsychotic and antidepressant medication. RNS #4 stated he/she is responsible for reviewing and revising the CCPs, but he/she has not been able to do it because he/she has been coveraing as a unit nurse due to the staffing issues. During a follow-up interview on 8/2/22 at 12:00 PM, the Director of Nursing (DON) stated Registered Nurse Supervisor (RNS) is the staff responsible for the care planning of the resident. However, RNS are currently covering the unit as unit nurse because there is a shortage of nursing stff. DON reviewed Resident #85's care plans and the Medication Administration Record (MAR) and stated a care plan for the psychotropic medication use was initiated but was not completed to include goals and interventions. DON further stated that there should have been one because the resident was taking psychotropic medications. 415.11(c)(1) 44842 45351 415.11(c)(1) (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842 Based on observation, record review, and interviews conducted during the Extended Recertification and Complaint survey (NY00292383, NY00295660 and NY00293005) from 07/21/2022 through 08/03/2022, the facility did not ensure residents were adequately supervised to prevent smoking accidents. This was evidenced for 4 of 4 residents reviewed for Smoking. (Resident #s 196, 82, 33, and 48) Specifically, the facility failed to provide adequate supervision and interventions to address residents with unsafe smoking and smoking in their rooms. Additionally, incidents of unsafe smoking were not investigated to determine adequate interventions to prevent recurrence. This was evident for 4 (Resident #s 196, 48, 82, and 33) of 4 residents reviewed for smoking. Resident #196 was identified as a smoker when admitted on [DATE] and had a BIMS score of 12 out of 15, indicating moderately impaired cognition. A smoking safety assessment was not completed, and a smoking care plan was not developed. A Social Work (SW) note dated 5/13/2022 documented the fire alarm sounded in Resident #196's room. The room smelled of smoke, a room search was done, and a cigarette box and ashes were found. Resident #196 was reminded the facility is smoke-free, and Resident #196 denied smoking. The Fire Alarm Report documented the fire alarm was triggered in Resident #196's room due to unsafe smoking on 3/18/2022, 5/1/2022, and 6/1/2022. There was no documented evidence Resident #196 was provided a 30-day discharge notice, had increased monitoring, or care planned interventions to address the unsafe smoking. There was no documentation the incidents of unsafe smoking were investigated. A SW Note dated 07/26/2022 documented Resident #196 was observed smoking marijuana in their room. Resident #196 was educated about the smoking policy, informed the facility is non-smoking, and offered a nicotine patch and gum. The SW documented the ethics committee would meet, and a 30-day discharge notice would be provided when a placement was found. Resident #s 48, 82, and 33 also had incidents of unsafe smoking that were not investigated. There was no evidence of increased monitoring or new interventions implemented after the incidents. During observations of the stairwells conducted on 7/26/22, surveyors smelled smoke and found cigarette butts throughout the stairwells. This resulted in Substandard Quality of Care that was Immediate Jeopardy (IJ) with the likelihood for serious injury, serious harm, serious impairment, or death to all residents smoking unsafely without adequate assessment and supervision. It was identified and declared. The IJ began on 07/26/2022 and was called on 07/27/2022 at 05:12 PM The facility submitted a removal plan on 07/28/2022 at 01:42 AM. IJ was removed 08/01/2022 at 05:36 PM. The findings include but are not limited to: The facility policy titled Smoking Free Facility dated 04/2020, documented the following: -The facility initiated a smoke free policy on April 2020 due to COVID-19 Public Health Emergency and will promote smoking cessation while ensuring resident safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Smoking is prohibited in all areas of the facility and residents admitted after the facility became smoke-free will be notified of this policy during the admission process, and as needed. -All residents will be asked about tobacco use urges during admission, quarterly, or upon comprehensive Minimum Data Set 3.0 (MDS) assessment. 1.) Resident #196 was admitted [DATE] with diagnoses of Seizure Disorder and Schizophrenia. The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #196 had mild moderately impaired cognition and required limited to extensive assistance to complete Activities of Daily Living (ADL). On 7/26/2022 at 12:25 PM, the South Stairwell (SS) alarm sounded, and Resident #196 was observed exiting the SS and entering the unit. Staff were not observed responding to the door alarm. Resident #196 was observed silencing the SS door alarm. On 07/26/2022 from 06:30 PM to 6:45 PM, observations of the SS were conducted: there was a strong odor of cigarette smoke; a burnt cigarette butt (CB) on the floor between the 5th and 6th floor; 4 CBs placed behind a fire hydrant pipe on the 5th floor landing; 3 CBs stuffed into cracks in the wall by the sprinkler pipe between the 3rd and 4th floor landings; 1 CB on the 4th floor landing; multiple CBs stuffed behind the fire standpipe risers of the 4th floor; 1 CB on the 2nd floor landing; and, 10 CBs in a space between the staircase and the wall between the 2nd and 1st floor. On 07/26/2022 at 06:48 PM, the North Stairwell (NS) 3rd floor landing was observed with 1 CB behind a fire hydrant pipe. The SW admission note dated 06/16/2021 documented Resident #196 identified themselves as a smoker, was informed of the facility smoking policy, and would be assessed for smoking. Fire Alarm Records dated 03/18/2022, 05/1/2022, and 06/1/2022 documented the fire alarm was triggered in Resident #196's room due to cigarette smoke. SW note dated 05/13/2022 documented the fire alarm sounded in the Resident #196's room. The room smelled of cigarette smoke, a room search was done, and a cigarette box and ashes were found. Resident #196 was reminded the facility is smoke-free. A SW note dated 07/26/2022 documented Resident #196 was observed smoking Marijuana in their room. Resident #196 was educated about the smoking policy, informed the facility is smoke-free, and offered a nicotine patch and gum. The ethics committee will meet, and a 30-day discharge notice will be provided to Resident #196 when a placement is found. There was no documented evidence the facility assessed Resident #196 for smoking, provided adequate supervision to prevent smoking incidents, investigated incidents of unsafe smoking, or addressed the resident's unsafe smoking with revised care plan interventions. (continued on next page)

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	335744	A. Building B. Wing	08/03/2022

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/27/2022 at 08:56 AM, the Registered Nurse (RN #2) assigned to Resident #196's unit, was interviewed and stated staff do not monitor resident use of the stairwells. Residents are not allowed to use the stairwell, but there are residents who use the stairwell when the elevator takes too long. Staff check the stairwells when the stairwell door alarms sound. 33315 2.) Resident #82 had diagnoses of End Stage Renal Disease (ESRD) on Hemodialysis and Diabetes. The MDS assessment dated [DATE] documented Resident #82 was cognitively intact and required limited to extensive assist with Activities of Daily Living (ADL). On 07/21/2022 at 10:01 AM and 07/25/2022 at 11:51 AM, Resident #82 was observed in bed in their room. The room had a strong odor of stale cigarette smoke. Resident #82 was interviewed and stated they smoke in their room sometimes because the facility does not address their smoking concerns. Resident #82 could not recall being informed of the facility smoking policy. Social Work (SW) Assessments dated 05/28/2021, 01/19/2022, and 05/26/2022 documented Resident #82 reported being a smoker. There was no documented plan to address Resident #82 as a smoker. A SW note dated 6/10/2022 documented the SW met with Resident #82 on multiple occasions due to noncompliance with smoking safety regulations, but Resident #82 continued to smoke in the facility. A Nicotine patch was offered, and the Medical Doctor (MD) was made aware. The was no documented evidence the MD evaluated and assessed Resident #82 for smoking cessation or intervention. A SW note dated 7/18/2022 documented Resident #82 was observed by nursing staff smoking in the facility despite being counseled on current regulations and guidelines. Resident #82 became verbally and physically aggressive by using profanity and throwing objects at staff. There was no documented evidence the facility assessed Resident #82 for smoking, provided adequate supervision to prevent smoking incidents, investigated incidents of unsafe smoking, or addressed the resident's unsafe smoking with revised care plan interventions. On 07/25/2022 at 12:04 PM, Certified Nursing Assistant (CNA) #1 was interviewed and stated they observe Resident #82 smoking in their room all the time. When the fire alarm goes off, the security announces the location of suspected smoke/fire, and the staff conduct a search of the room. CNA #1 never found smoking materials when they searched residents' rooms. The Registered Nurses (RN) Supervisors, SW, and Administrator are aware there are constant smoking issues. On 07/25/2022 at 11:54 AM, an interview was conducted with RN Supervisor #1 who stated the facility is smoke-free, and most of the smokers don't leave the building to smoke. Some of the smoking residents smoke in their rooms, and the alarm goes off very often. RN Supervisor #1 was not aware of a facility plan to address the smoking residents. The staff reinforce with smoking residents that the facility is smoke-free. 46035 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3.) Resident #33 was admitted to the facility on [DATE] with paraplegia due to spinal cord injury and major depressive disorder. The MDS dated [DATE] documented Resident #33 was cognitively intact and required the extensive assist of two people for bed mobility and transfers. The Baseline Comprehensive Care Plan (CCP) dated 11/24/2021 documented Resident #33's status as a smoker was a safety concern. On 07/21/2022 at 10:02 AM, Resident #33 was observed in their room and the room had strong cigarette smoke smell. The Social Work (SW) assessment dated [DATE] documented Resident #33 smokes cigarettes. The SW notes dated 04/28/2022, 5/05/2022, 5/06/2022, and 06/10/2022, documented Resident #33 was counseled on facility regulations and guidelines due to smoking in the facility. Resident #33 continued to be noncompliant, and a nicotine patch was offered. There was no documented evidence the facility assessed Resident #33 for smoking, provided adequate supervision to prevent smoking incidents, investigated incidents of unsafe smoking, or addressed the resident's unsafe smoking with revised care plan interventions. On 07/27/2022 at 10:39 AM, Housekeeper was interviewed and stated residents use the stairwell. The Housekeeper found cigarette butts in the stairwell previously and reported it to their supervisor. On 7/26/2022 at 11:12 AM, the Director of SW (DSW) was interviewed and stated the DSW informs potential residents the facility is smoke-free prior to admission by providing brochures and facility information to the hospital discharge planner. Potential residents are aware the facility is smoke-free and the DSW is not involved in approving potential residents for admission. The SWs meet with residents on the first day they are admitted to the facility and reinforces the facility is smoke-free. Residents with a history of smoking are offered nicotine gum and patches or a transfer to a facility that allows smoking. If a resident violates the smoking policy, the DSW searches their room, revokes their visitation and out-on-pass privileges, and gives them a 30-day discharge notice. The issue of unsafe smoking began in 10/2021 and, in the past, the facility issued 30-day discharge notices to 2 residents due to unsafe smoking. On 07/26/22 at 11:17AM, an interview was conducted with the Director of Nursing (DON) who stated prospective residents are informed the facility is smoke-free prior to admission. Noncompliant unsafe smoking residents receive counseling from the SW. Residents are offered smoking cessation. Resident family members were notified the facility became smoke free and not to bring in cigarettes to the residents. The unsafe smokers are having difficulty accepting the facility smoking policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/26/2022 at 11:29 AM, the Administrator was interviewed and stated residents continue to smoke despite the facility being smoke-free. Noncompliant residents are counseled, informed they may receive a 30-day discharge notice, and the family is made aware. Residents and visitors bring smoking materials into the facility. The Administrator did not identify smoking as a concern. The Administrator stated he/she did not think the unsafe smokers in the facility required assessments and care plan interventions because the facility became smoke-free, and the residents were informed of the policy upon admission. On 07/27/2022 05:12 PM, Immediate Jeopardy (IJ) was identified and declared. The facility Administrator and Director of Nursing were notified. On 07/28/2022 at 01:42 AM, the facility submitted a removal plan that was reviewed and accepted by the NYSDOH. On 08/01/2022 at 05:36 PM, the survey team declared the IJ was removed based on the following corrective actions taken by the facility: 1- For Resident #196 and Resident #82, smoking assessments, Smoking Comprehensive Care Plans (CCP), and smoking contracts were completed. Both residents were observed with one-to-one monitoring, room searches conduct every 4 hours and no further smoking safety concerns identified. All corrections completed by 7/30/2022 2- For Resident #33, a review of nurse's progress note dated 07/24/2022 documented that the resident was transferred to the hospital due to other medical related condition. 3- Resident # 48, smoking assessment was done on 7/29/2022. MD order dated 7/29/2022 at 7:29pm documented allowed to smoke per facility protocol. Smoking care plan effective 7/29/2022. Smoking contract signed 7/30/2022. 4- All residents were reviewed, and the smoking list was updated. All other residents identified as smokers were assessed for safety and smoking care plans were developed and completed as of 08/01/2022. 5- A new smoking policy was developed on 7/2022. The revised policy ensured consistency in assessing residents for smoking, care plans and supervisions. 6- In-service lesson plan and sign-in sheets were reviewed 08/01/2022 and education was provided to 90% of staff (department heads, Administration, Nursing, MDS Department, Dietary, Housekeeping/Maintenance, Recreation, Social Work, Rehabilitation Department) regarding smoking safety protocols, accident/incident reporting, and the revised smoking policy. 7- Interviews were conducted with the following staff regarding smoking safety protocols on from 7/28/2022 through 8/1/2022 the following staff were inserviced and knowledgeable re: the facility's smoking policy: RN = 7, Licensed Practical Nurse = 12, CNA = 25, Therapeutic Nursing Aide = 3 Personal Care Attendant = 1, Medical Doctor = 1, Nurse Practitioner = 1, DSW = 1, Director of Rehabilitation = 1, Certified Occupational Therapy Aide = 2, Physical Therapy Aide = 2, Recreation = 4, Maintenance/Housekeeping = 4, Security = 3, Admissions = 1, SW = 2, and the Administrator = 1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview and record review conducted on 08/01/2022, the facility fully implemented the IJ Removal Plan, and the IJ was removed as of 08/01/2022 at 5:36 PM. 415.4(a)(2-7)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842 Based on record review and interviews conducted during the Extended Recertification and complaint survey (NY00290022) from 7/21/2022 through 8/03/2022, the facility did not ensure that medical records were maintained on each resident that were complete and accurately documented in accordance with professional standards and practice. Specifically, the Medication Administration Record did not contain documentation of medication administration for 9 of 11 prescribed medication days in January 2022 and for 10 of 18 days in February 2022 for multiple medications. This was evident for 1 of 5 residents reviewed for Medication Administration out of sample size of 47 residents. (Resident # 366). The findings are: The Medication Administration and Documentation-General Policy #PHNY69 revised May 2018 documented that the LPN (Licensed Practical Nurse) documents administration of medication on the MAR or eMAR immediately following administration, documents any medication not administered (i.e., refused, etc.,) and documents reason, documents specific reason and result for each dose of as needed medication on the MAR, documents all held or refused medication on MAR or eMAR, and uses prudent professional judgement by informing Physician in a timely manner when medications, held, refused or otherwise unavailable for administration. Resident #366 was admitted to the facility with diagnoses that included Chronic pain due to trauma, Postherpetic trigeminal neuralgia, and Hypertension. Admission MDS dated [DATE] documented the resident had intact cognition, no behaviors, and no rejection of care. The following medications were not documented on the Medication Administration Record dated January 2022: Senna 8.6 mg tablet (give 2 tablets (17.2 mg) by oral route once daily for constipation unspecified was not documented at 5PM from 1/24/2022 to 1/28/2022, Pantoprazole 40 mg delayed release tablet at 6:30AM (give 1 tablet daily orally) was not documented from 1/21/2022, 1/22/2022, and 1/24/2022, Mirtazapine 45mg tablet (give 1 tablet by oral route daily before bedtime) was not documented on 1/21/2022, 1/22/2022, from 1/24/2022 to 1/28/2022, and on 1/30/2022, Gabapentin 100mg (give 5 capsules by oral route three times a day) was not documented at 1PM from 1/23/2022 to 1/27/2022, 1/31/2022 and at 5PM pm from 1/24/2022 to 1/28/2022, Cholecalciferol (Vit D3) 10 mcg (400 unit) chewable tablet order start 1/21/2022 at 12:00am was not documented on 1/21/2022, 1/22/2022, and 1/24/2022. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following medications were not documented on the Medication Administration Record dated February 2022: Venlafaxine ER 150 mg capsule extended release 24 hour (give 1 capsule (150 mg) was not documented on 2/1/2022, 2/2/2022, from 2/4/2022 to 2/6/2022, and 2/12/2022, Senna 8.6mg tablet (give 2 tablets by oral route once daily) was not documented on 2/1/22, from 2/4/2022 to 2/6/2022, 2/8/22, 2/13/2022, and 2/14/2022, Pantoprazole 40mg delayed release tablet (give 1 tablet by oral route once daily) was not documented on 2/1/22, 2/6/22, and 2/7/22, Mirtazapine 45 mg was note documented on 2/1/22, from 2/4/2022 to 2/6/2022, 2/8/22, 2/13/2022, and 2/14/2022, Gabapentin was not documented at 9:00AM on 2/1/2022, 2/2/2022, from 2/4/2022 to 2/6/2022, and 2/12/2022; at 1pm on 2/1/2022, 2/2/2022, from 2/4/22 to 2/7/2022 and 2/12/2022, and at 5PM on 2/1/2022, from 2/4/2022 to 2/6/2022, 2/8/2022, 2/13/2022 and 2/14/2022, Enalapril maleate 20 mg tablet was not documented on 2/1/2022, 2/2/2022, from 2/4/2022 to 2/6/2022, and 2/12/2022, and Cholecalciferol 10 mcg tablet was not documented on 2/1/2022, 2/6/2022, and 2/7/2022. On 07/28/2022 at 5:05PM, Registered Nurse (RN) #3 was interviewed. RN #3 stated that some residents want to take meds exactly at the time ordered and some medications interact with each other. RN #3 also stated that the ratio is 1 nurse per 40 residents and medications are always given 1 hour before or after ordered time. RN #3 further stated they always administer resident medications within the time frame. On 08/02/2022 at 12:49PM, the Director of Nursing (DON) was interviewed and stated that they have the supervisor check at the start and end of the shift for completion and omission of documentation on the MAR. The DON also stated that some medications were not signed for and not accounted for on the resident's February 2022 MAR and the supervisor should have picked up on it and alerted the nurse. Attempts to contact RN #2 and RN #3 regarding missing documentation on the MAR on 8/3/22 were unsuccessful. On 08/03/22 at 11:28 AM, RN #1 was interviewed and stated that the days that they did not initial the MAR after administering medications was due to their heavy workload. RN #1 also stated that they usually run a report to check for omissions on the MAR and they would sometimes enter their initials on the next day when this happened. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/02/22 at 12:17 PM, LPN #2 was interviewed and stated that according to the legend, the dashes on resident's February MAR indicates the nurse did not document that medication was administered. LPN #2 also stated they forgot to put their initial in slots on the January MAR. At the end of every shift every nurse is responsible to review the dashboard & make sure they have documented in the resident's MAR. Also, the medication would show up in red if the medication was late. LPN #2 further stated they have a time limit in which to give medications and a medication that was not documented does not mean the resident did not receive the medication. LPN #2 stated that Resident #366 would remind the nurse when it is time for their medication and would not let the nurses forget to give them their medication and the resident had not refused any medications when they were on duty. 415.12