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	05/20/2022

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39170 Based on observation, interviews and record review conducted during an abbreviated survey (NY00291980) and (NY00272561), the facility failed to ensure that residents were free from physical abuse. This was evident in 2 out of 3 residents sampled (Resident #1 and Resident #3). Specifically, 1). On 02/28/2022, Resident #2 witnessed Licensed Practical Nurse (LPN) #1 punch Resident #1 in the face. Resident #1 was transferred to the emergency room (ER) and was diagnosed with closed fracture of the nasal bone. 2) On 03/11/2021 at approximately 5:00AM, LPN #2 sprayed an unknown disinfectant at Resident #3. Resident #3 complained of burning and redness to the eyes. Nursing Supervisor #2 assessed Resident #3 with redness to the eyes. This resulted in actual harm to Resident #1 and Resident #3 that is not Immediate Jeopardy. The findings are: Review of the facility's policy and procedure entitled Abuse, Neglect and Exploitation Program effective in 09/2018 and reviewed 03/2022 documented: It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The facility will establish policies and procedures to investigate any such allegations and include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and Dementia management and resident abuse prevention. The facility will provide ongoing oversight and supervision of staff to assure that its policies are implemented as written. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. 1) Resident #1 was admitted to the facility with diagnoses including Hypertension and Dementia. The Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12/15 indicating moderately impaired cognition. A Comprehensive Care Plan (CCP) titled Peer Abuse Prevention/Victimization initiated on 03/10/2020 and updated on 12/14/2021, documented interventions to allow Resident #1 to vent feelings and Social Worker to counsel the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's Summary of Investigation dated 03/01/2022 documented that on 02/28/2022 at around 6:30 AM, Nursing Supervisor #1 was paged to Resident #1's unit. Resident #1 alleged that LPN #1 punched him/her on the face. Resident #1 was bleeding from the nose. Nursing Supervisor #1 assessed Resident #1 and observed a blood stain on Resident #1's hand. There were no skin break or marks on Resident #1's face. Resident #1 declined further body assessment. The resident called 911 and was transferred to the hospital. Resident #1 returned from the hospital at 7:30 PM without any hospital paperwork. On 03/01/2022, the facility followed up with the hospital and the ER Summary was faxed to the facility. The Computed Tomography (CT) scan of the head and maxillofacial (face and jaw) showed closed fracture of the nasal bone. LPN #1 denied hitting Resident #1. LPN #1 stated that during medication pass on 02/28/2022 at 6:00 AM, Resident #1 asked LPN #1 to leave the medication on Resident #1's bedside table and LPN #1 left the room. LPN #1 stated that Resident #1 came out of the room, very aggressive, cursed LPN #1 and threw a box of milk at LPN #1. LPN #1 stated that he/she followed Resident #1 to the room to find out what was going on and Resident #1 grabbed LPN #1's mask off LPN #1's face. The surveillance camera showed Resident #1 came out of the room and threw a box of milk at LPN #1 in the hallway. LPN #1 then followed Resident #1 to the room right afterwards and closed the door. Within a few, LPN #1 came out of Resident #1's room without a face mask and went back to the medication cart. The investigation concluded that a reasonable suspicion of allegation of abuse with an injury or actual harm occurred to Resident #1. A review of a Nursing Progress Note, by Nursing Supervisor #1, dated 02/28/2022 at 7:15 AM documented that Resident #1 was observed with blood stain on the resident's hand. Resident #1 refused assessment and vital signs. A review of a Nursing Progress Note, by Nursing Supervisor #1 dated 02/28/2022 at 7:17 AM documented that Resident #1 called 911 at about 7:00 AM and requested to be transferred to the hospital for nosebleed. The Nurse Practitioner (NP) notified, and Resident #1 was transferred to the hospital. A review of a Nursing Progress Note dated 02/28/2022 at 8:03 PM documented that Resident #1 arrived back to the facility unaccompanied via ambulette. Resident #1 was welcomed back to his/her room. On assessment there was no respiratory distress. Vital signs checked and recorded. Resident #1 denied any pain. A review of the hospital After Visit Summary dated 02/28/2022 documented diagnosis: Closed Fracture of Nasal Bone, Imaging tests: CT of head without contrast, CT of Maxillofacial without contrast. Medication given: Tylenol (Acetaminophen) last given at 8:13 AM. No scheduled appointment. Follow up with plastic surgery clinic if the resident needed it repaired. A Review of the Medication Administration Record dated 03/04/2022 at 11:00 PM documented that Acetaminophen 325 MG 2 tablets (650 MG) orally was administered to Resident #1 for pain. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a Medical Progress Note, by Physician #1, dated 03/08/2022 at 12:00 PM documented Late Note: Chief Complaint (CC): Facial fracture: Resident #1 was seen today, according to Resident #1, he/she had what started as a verbal altercation with LPN #1 regarding Resident #1 taking his/her morning medications. This altercation escalated with Resident #1 apparently becoming angry and throwing his/her milk at LPN #1. As per Resident #1's report, he/she was then followed into his/her room and was struck in the face by LPN #1. In the ER a CT scan of the face revealed an acute fracture of the nasal bone. Resident #1 continues to complain of pain in the fractured area. Resident #1 denied headache. Head, Eyes, Ear, Nose and Throat (HEENT): there is a depressed nasal bone fracture with surrounding erythema (superficial redness of the skin), edema (swelling), and tenderness at the bridge of the nose with surrounding ecchymosis (blood or bleeding under the skin due to trauma of any kind) on the left, just under the eye. The pupils are equally reactive to light and accommodation, normal extraocular (muscle that control the movements of the eye) eye movements. Assessment / Plan- Nasal bone fracture - Allegedly suffered at the hands of a staff member. No intervention is necessary at this time as this does not represent a displaced fracture. Continue pain management. Follow for any subsequent sequelae (a condition which is the consequence of a previous disease or injury). During an interview on 04/18/2022 at 2:30 PM, Resident #2 stated that he/she was in an adjoining room next to Resident #1's room. Resident #2 stated that they shared the same bathroom. Resident #2 stated that he/she responded to the commotion between Resident #1 and LPN #1. Resident #2 stated that he/she observed Resident #1 standing in the bathroom doorway towards Resident #2's room. Resident #2 stated that LPN #1 was also in the bathroom. Resident #2 stated that he/she saw LPN #1 punch Resident #1 in the face and that Resident #1 fell on the bathroom floor. Resident #2 stated that after Resident #1 fell , LPN #1 left the room. Resident #2 stated that Resident #1 was bleeding from the nose. Resident #2 stated there were drops of blood on the floor in the bathroom and Resident #2 wiped the blood off the floor. Resident #2 stated that the facility interviewed him/her, and he/she told the facility what happened. During an interview on 04/18/2022 at 4:08 PM, LPN #1 stated that he/she did not hit or touch Resident #1 on 02/28/2022. LPN #1 stated that he/she went to give Resident #1 medication around 6:00 AM on 02/28/2022 and Resident #1 wanted LPN #1 to leave the medication on Resident #1's bedside table. LPN #1 stated that he/she refused to leave the medication in Resident #1's room. LPN #1 stated that he/she exited Resident #1's room to continue medication administrations and Resident #1 followed him/her out of the room to the hallway yelling. LPN #1 said that Resident #1 threw a box of milk at him/her and went back to Resident #1's room. LPN #1 said that he/she followed Resident #1 to the room to talk to Resident #1. LPN #1 stated that Resident #1 suddenly punched LPN #1 in the face and pulled off LPN #1's face mask causing a scratch. LPN #1 stated that Resident #1 ran in the bathroom leading to the other room. LPN #1 stated that he/she left Resident #1's room and called the Nursing Supervisor #1. LPN #1 stated that he/she did not see Resident #2 while in he/she was in Resident #1's room. LPN #1 also stated that he/she did not observe any bleeding from Resident #1's nostril and did not see any blood on the floor in Resident #1's room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/19/2022 at 10:05 AM, Nursing Supervisor #1 stated that he/she responded to the unit on 02/28/2022 around 6:00 AM. Nursing Supervisor #1 stated that LPN #1 reported that Resident #1 was aggressive towards LPN #1. Supervisor #1 stated that Resident #1 was alert and verbally responsive. Nursing Supervisor #1 stated that Resident #1 was holding Resident #1's nose and there was a small amount of blood on Resident #1's hand. Nursing Supervisor #1 stated that he/she did not see any blood on the room and bathroom floors. Nursing Supervisor #1 stated that Resident #1 did not say that he/she fell or had pain. Nursing Supervisor #1 stated that Resident #1 was uncooperative with assessment. Nursing Supervisor #1 said that Resident #1 had called 911 and they responded while he/she was on the unit. Nursing Supervisor #1 said that he/she observed milk splashed on the floor near Resident #1's room. During the subsequent interview conducted with Nursing Supervisor #1 on 05/20/2022 at 3:10PM. Nursing Supervisor #1 stated that he/she did not check LPN #1's hands for blood or injury. Nursing Supervisor #1 also stated that he/she did not observe any scratch mark on LPN #1's face. During an interview on 04/19/2022 at 10:55 AM, through language bank interpreter, Resident #1 stated that the nurse (LPN #1) went into his/her room and slammed the door. Resident #1 stated that LPN #1 then punched him/her in the face and fractured his/her nose. During an interview on 05/13/2022 at 12:25 PM, Physician #1 stated that he/she worked at the facility for about two to three months and was Resident #1's Primary Physician. Physician #1 stated that he/she recalled that he/she saw Resident #1 a few days after the incident. Physician #1 stated that Resident #1 reported that Resident #1 was punched in the face by the nurse (LPN #1). Physician #1 stated that he/she examined Resident #1 and Resident #1 had a closed non-displaced Nasal Bone Fracture with bruising and tenderness to the nose and surrounding area under one of the eyes. Physician #1 stated that the medical management was for the nasal fracture to heal by secondary intention, since the fracture was closed. Physician #1 stated that they ensured that Resident #1's vision was not affected and Resident #1's pain was controlled. Physician #1 stated that Resident #1's pain was mild, and it was controlled with Tylenol tablets. During an interview on 05/12/2022 at 11:17 AM, the Director of Nursing (DON) stated that the facility concluded that there was cause to believe that Resident Abuse occurred because of the Nasal Fracture injury that Resident #1 sustained. The DON stated that Resident #1 stated that LPN #1 punched him/her in the face. The DON stated that Resident #2 also reported that he/she witnessed LPN #1 punch Resident #1 in Resident #1's face. Subsequent interview was conducted with the DON on 05/20/2022 at 3:45 PM. The DON stated that LPN #1 was already sent home when 911 and the Police responded on 02/28/2022. The DON stated that there was a follow up phone call to the Police on 03/01/2022 but does not know if LPN #1 was arrested. The DON stated that he/she does not know the exact length of time LPN #1 was in Resident #1's room but it was for a short time. 2) Resident #3 was admitted to the facility with diagnoses including Diabetes Mellitus (DM) and Schizophrenia. The Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #3 had a Brief Interview for Mental Status (BIMS) score 12/15 indicating moderately impaired cognition. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A Comprehensive Care Plan (CCP) titled Peer Abuse Prevention initiated on 01/03/2020 and updated on 02/23/2021 documented interventions to allow Resident #3 to vent feelings, counsel by Social Worker and family involvement if needed. A Facility Investigation Summary dated 03/12/2021 documented that on 03/11/2021 at approximately 5:00 AM, Resident #3 reported to the Nursing Supervisor #2 that while Resident #3 was at the nurses station asking about another staff member from Activities, LPN #2 appeared upset about something and started spraying a disinfectant spray on the countertop and up in the air spraying in the direction of Resident #3's face. Resident #3 stated that it hurt his/her eyes. Nursing Supervisor #2 immediately assessed Resident #3's eyes and noted slight redness in both eyes. Resident #3 was directed to the eye wash station and rinsed both eyes. After completing the rinse, the Nursing Supervisor #2 stated that both eye redness subsided within minutes. Physician #2 was informed, and staff were ordered to monitor the resident for further adverse reactions. An interview was conducted with LPN #2 who stated that Resident #3 kept coming to the nurse's station without a mask despite redirection. LPN #2 stated that he/she brought his/her own spray because of COVID. Based on camera footage, LPN #2 sprayed an unknown aerosol towards the direction of Resident #3 and Resident #3 sustained redness to both eyes. LPN #2 was suspended immediately and was eventually terminated. Resident #3 was seen by Physician #2 and Optometry Consult with impression of DM, Glaucoma, Cataracts. The facility concluded that there was probable cause to believe Abuse, Neglect or Mistreatment occurred. A review of a Nursing Progress Note, by Nursing Supervisor #2, dated 03/18/2021 at 6:08 AM documented that Resident #3 complained of burning sensation to his/her eyes and face and reported that LPN #2 sprayed disinfectant on his/her eyes and face. Wash with a lot of soap and water. A review of a Nursing Progress Note, by Nursing Supervisor #2, dated 03/18/2021 at 6:09 AM documented above incident happened 03/11/2021 at 5AM. The facility's surveillance recording video was reviewed on 04/20/2022 at 1:50 PM with the Administrator: On 03/11/2021 at 5:55 AM, Resident #3 was seen walking towards the nurse's station. At 5:55 AM, LPN #2 and CNA #1 were seated behind the desk in the nurse's station. At 5: 55:13 AM, Resident #3 approached the nurse's station. LPN #2 started spraying a liquid in a bottle on the desk. At 5:55:18 AM, Resident #3 was seen standing directly in front of the desk at the nurse's station. At 5:55:22 AM, LPN #2 was seen pointing the spray bottle and spraying in the direction of Resident #1. At 5:55:28 AM, CNA #1 was seen handing Resident #2 a face mask and Resident #2 walked away from the nurse's station. This surveyor made several attempts to contact LPN #2 but was unsuccessful. A certified mail was sent out with no response to date. During an interview on 05/10/2022 at 1:10 PM, Nursing Supervisor #2 stated that on 03/11/2021 at around 6:00 AM, Resident #3 reported that LPN #2 sprayed disinfectant in Resident #3's eyes. Nursing Supervisor #2 stated that Resident #3 said that his/her eyes were burning. Nursing Supervisor #2 stated that he/she assessed Resident #3's eyes and observed slight redness to both eyes. Nursing Supervisor #2 stated that he/she washed Resident #3 's eyes with water and informed the DON. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/12/2022 at 11:12 AM, the DON stated that as per the surveillance video review of the incident involving Resident #3 and LPN #2, there was cause to believe that staff to resident abuse occurred. The DON stated that the video showed that LPN #2 pointed the disinfectant spray at Resident #3. The DON stated that LPN #2 had prior Inservice on Abuse and LPN #2 was terminated from employment. 415.4(b)(1)(i)