STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335744	A. Building B. Wing	11/19/2021

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 0635 Level of Harm - Actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39170 Based on observations, interviews and record review conducted during an abbreviated survey (NY00285166) on 11/03/2021, the facility did not have physician orders for a resident's immediate care. This was evident in 1 out of 4 residents sampled (Resident #1). Specifically, Resident #1 was admitted from the hospital to the facility on [DATE] with discharge orders for Valproic Acid (Seizure medication). The Valproic Acid was not ordered, and Resident #1 did not receive the medication. Resident #1 had a Seizure on 10/11/2021 and was transferred to the emergency room (ER). On 10/12/2021, Resident #1 was transferred back to the facility with discharged orders from the ER for Depakene (Valproic Acid) Syrup 1125 mg every 12 hours. The Depakene Syrup was not ordered in the facility, and Resident #1 suffered another Seizure on 10/17/2021 and was transferred to the ER. Resident #1 missed 16 days (32 dosages) of Seizure medication, suffered Seizures and two hospital transfers before facility staff became aware that the hospital and emergency room Discharge Orders, for the Valproic Acid, were not implemented. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The findings are: Review of the facility's policy and procedure entitled Admissions, Transfers and Discharges last revised in April 2019 documented: The facility will admit only those residents whose, medical and nursing care needs can be met. Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least: type of diet, medication orders and routine care orders. A facility Summary of Investigation dated 10/26/2021 documented that there was an order for Valproic Acid for Resident #1 that was missed on the initial admission on 10/01/2021. Resident #1 was transferred to the hospital on 10/11/2021 for evaluation of seizures. Resident #1 returned from Hospital on 10/12/2021 with recommendations to start Valproic Acid, Registered Nurse (RN) #1 did not review the emergency room (ER) Discharge Paperwork and the Physician did not follow up on Resident #1's ER Discharge recommendations. The facility concluded that both the Nursing Supervisor and Resident #1's Attending Physician failed to locate the emergency room Discharge Summary upon Resident #1's return to the facility on [DATE]. The hospital recommendation for Resident #1 to start Valproic Acid was not followed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0635 Level of Harm - Actual harm Residents Affected - Few	Resident #1 was initially admitted to the facility on [DATE] with diagnoses including Autism, Seizure Disorder and Cerebral Palsy. The Minimum Data Set (MDS, a resident assessment tool) dated 10/08/2021 documented that Resident #1 had intact long/short-term memory and had severely impaired decision-making ability. Resident #1 previously resided in a Group Home prior to his/her hospitalization and admission to the facility. A Hospital Inpatient Discharge Summary dated 09/26/2021 documented: Reason for Admission: Small Bowel Obstruction, Septic Shock, and Pneumonia. History included Autism, Seizure Disorder, History of Aspiration Pneumonia, and Mental Disability (Cerebral Palsy). The Active Medication List included Valproate Sodium 500 mg in Dextrose 5% 50ml IVPB (intravenous piggyback), 500 mg 50/ml/hr. IV Q6H. (Home medications included Valproate 1125mg every 12 hours). A Nursing Correction Progress Note dated 10/01/2021 at 10:15 PM documented that Resident #1 was admitted from the hospital at about 8:55 PM accompanied by 2 Emergency Medical Service (EMS). Resident #1 had Past Medical History (PMHX) of Autism, Seizure, History of Aspiration, Mental Disability, Cataracts, Dysphagia, Non-Alcoholic Fatty Liver Disease (NAFLD) and Raynaud's Disease. On assessment Resident #1 was non-verbal, confused, and disoriented. A Physician's Order Activity Detail Report for 10/01/2021 and 10/02/2021, revealed that there was no order for Valproate Sodium medication. A Neurological Function with Risk for Seizure related to Seizure Disorder Care Plan was initiated on 10/02/2021. The interventions included administer medications as ordered, observed for side effects, effectiveness, and observe for change in mental status. A Medical Correction Comprehensive Physician Admission Note dated 10/02/2021 at 7:34 AM documented that Resident #1 was discharged from hospital on 10/01/2021. All hospital paperwork reviewed. Medications included Lorazepam 2mg, give 2 tabs (4mg) by PEG every 6 hours for 15 days as needed for Anxiety, Clonazepam 0.5mg tablet, give 1 tablet by Percutaneous Endoscopic Gastrostomy (PEG) 2 times a day for 14 days as needed for anxiety. Listed diagnoses included Seizure Disorder. There was no mention of Valproic Acid for Seizure Disorder. A Nursing Progress Note dated 10/11/2021 at 9:35 PM documented that Resident #1 was observed with seizure activity twice. The seizures lasted 2 to 3 minutes. The Physician was notified and ordered that Resident #1 be transferred to the hospital. Resident #1 left the facility via Emergency Medical Service (EMS) at 9:00 PM. The emergency room Discharge Summary (ERDS) dated 10/12/2021 documented Valproate Level collected on 10/11/2021 at 10:50 PM. The result documented that Resident #1's Valproic Acid level was <20.0ug/ml (reference range 50.0-140.0ug/ml). The discharge summary documented Patient was supposed to be on Depakene Syrup 1125mg every 12 hours, however this was not listed in the Nursing Home medications. Resident #1 presented to the Emergency Department (ED) on 10/11/20221 with two witnessed convulsive seizures at the nursing home. The Valproic Acid level found to be subtherapeutic. It was likely that the resident was not getting the scheduled doses at the Nursing Home. Resident #1 was observed to have myoclonic jerks on presentation to the ED. Restart Valproic Acid 1125mg two times a day (Depakene syrup through the PEG tube). (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 0635 Level of Harm - Actual harm Residents Affected - Few	A Nursing Progress Note dated 10/12/2021 at 7:16 PM documented that Resident #1 had returned from the hospital at 5:00 PM. Resident #1 was in stable condition. The tube feeding was completed, and medication given via gastrostomy (GT). There was no documentation that the physician was notified of Resident #1's return to the facility. There was no documentation that the discharge summary was reviewed and there was no mention of Valproic Acid. A Physician's Order Activity Detail Report for 10/12/2021 revealed that there was no order for Valproic Acid/Depakote. A Physician's Progress Note dated 10/15/2021 at 6:32 AM documented that Resident #1 was seen at the bedside. Chief Complaint (CC): follow up of Infection. The physician's progress note did not mention the hospital recommendation to start Resident #1 on Valproic Acid for Seizure Disorder. A Nursing Progress Note dated 10/17/2021 documented that at about 5:20 AM, Resident #1 was observed by private caregiver with seizure activity. The caregiver described it as sudden, jerky and shaking movement which lasted about 1 minute. On assessment, Resident #1 was back to baseline. The Physician was notified and recommended transfer to the hospital for evaluation. A Physician's Order dated 10/17/2021 at 3:15 PM documented Valproic Acid (as sodium salt) 250mg/5ml oral solution, give 22.5mls (1125mg) by PEG tube route every 12 hours. A Nursing Progress Note dated 10/17/2021 at 3:24 PM documented that Resident #1 returned from hospital at approximately 1:12 PM via stretcher accompanied by 2 Emergency Medical Technicians. The resident was alert and responsive, in no distress. New order for Depakene 1,125mg ordered. The Physician was notified, and the medication transcribed in Medication Administration Record (MAR). A Review of the Medication Administration Record (MAR) dated 10/18/2021 documented that Valproic Acid 1125mg by PEG tube every 12 hours was administered on 10/18/2021 at 9:00 AM. A Nursing Progress Note (late entry for 10/12/2021) dated 10/20/2021 at 4:47 PM documented no new medical order received by writer upon Resident #1's return from the hospital. A Physician's Progress Note dated 10/20/2021 at 6:19 AM documented that Resident #1 was seen at the bedside. There was no documentation of the discharge summary or the Seizure medication. An Activities of Daily Living (ADL) Functional Rehab Potential with Focus Cardiac Function secondary to Seizure Disorder, Care Plan updated on 11/02/2021 documented interventions to provide seizure medications as per Physician's order and Neurology Consult per Physician's order. (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 0635 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/03/2021 at 1:30 PM, the Mental Hygiene Nurse Program Coordinator from New York State Developmental Disabilities Office stated that on 10/17/2021, he/she received a call from the Hospital Physician regarding Resident #1. The Hospital Physician informed the Nurse Program Coordinator that Resident #1 was in the emergency room and the level of Resident #1's seizure medication was zero. The Nurse Program Coordinator further stated that he/she assigned a Group Home Registered Nurse (GHRN) to go to the facility to see Resident #1. The Nurse Program Coordinator added that the GHRN stated that he/she observed Resident #1's hospital discharge papers on the bedside table in Resident #1's room. The Nurse Program Coordinator added that he/she request a meeting and a plan of correction from the facility. During an interview on 11/03/2021 at 1:40 PM, the GHRN stated that he/she went to the facility on [DATE] to reconcile Resident #1's medications around 3:00 PM. The GHRN stated that he/she requested a printout of Resident #1's medications from the charge nurse. The printout showed that Resident #1's medications did not include Valproic Acid. The GHRN went to Resident #1's room and observed the hospital discharge papers dated 10/12/2021 on Resident #1's bedside table. The GHRN stated that a companion was with Resident #1 in the room and stated that the discharge papers were in Resident #1's room. The GHRN stated that he/she went to the nurse and alerted him/her about the finding of the hospital discharge summary. The GHRN added that the facility entered the Valproic Acid medication order for Resident #1 after 3:00 PM on 10/17/2021, while he/she was onsite at the facility. During an interview on 11/03/2021 and 11/18/2021, Resident #1's Attending Physician stated that he/she was the Physician who admitted Resident #1 on 10/01/2021. The Attending Physician stated that he/she reviewed the Patient Review Instrument (PRI), Resident #1's history and the Hospital Discharge Summary the same night of Resident #1's admission. The Attending Physician verbalized that he/she missed the order for the Valproic Acid when he/she reviewed Resident #1's hospital discharge summary on 10/01/2021. The Attending Physician stated that he/she was aware that Resident #1's had Seizure Disorder diagnosis but was not sure if Resident #1 was on any medications for the Seizure Disorder. The Attending Physician said that he/she was informed that Resident #1 had Seizures on 10/11/2021 and ordered Resident #1 to be transferred to the ER for evaluation. The Attending Physician said that he/she did not find the Hospital Discharge Summary for 10/12/2021 after Resident #1 returned to the facility. The Attending Physician stated that he/she asked the unit nurse and the nursing supervisor for Resident #1's hospital Discharge Summary and instructed them to call the hospital for the discharge summary. The Attending Physician was unable to state the names of the staff who he/she asked for Resident #1's Hospital Discharge Summary. The Attending Physician also said that he/she called the hospital for Resident #1's Discharge Summary on 10/12/2021 but he/she did not get to speak to anyone. The Attending Physician stated that he/she did not speak to the Medical Director or to the Director of Nursing (DON) regarding Resident #1's missing Hospital Discharge Summary for 10/12/2021. (continued on next page)

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F 0635 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/03/2021 and 11/19/2021, RN #1 stated that he/she worked as the Nursing Supervisor when Resident #1 was transferred to the hospital on 10/11/2021 and when Resident #1 returned from the hospital on 10/12/2021. RN #1 said that he/she checked Resident #1's diagnoses and medications but could not remember if he/she had seen Resident #1's Seizure Disorder diagnosis and that Resident #1 had medication for Seizure Disorder. RN #1 verbalized that when he/she worked as a Nursing Supervisor, his/her responsibility included checking Resident #1's Hospital Discharge Summary or emergency room Discharge Summary to see if there were any new orders and to notify the Physician. RN #1 said that he/she asked Resident #1's companion about the hospital discharge papers but the companion told RN #1 that Resident #1 had no discharge papers. RN #1 also said that he/she called the hospital but did not reach anyone. RN #1 further stated he/she did not ask the incoming shift to follow up with the hospital and that he/she did not notify the DON. During an interview on 11/04/2021 at 1:50 PM, Registered Nurse Supervisor #1 (RNS #1) stated that he/she was the Nursing Supervisor for the night shift on 10/01/2021 and performed Resident #1's admission assessment. RNS #1 said that he/she reviewed the PRI and entered the orders in the Electronic Medical Record (EMR) then notified the Physician. RNS #1 said that he/she was not sure if there was a Hospital Discharge Summary for Resident #1 on 10/01/2021 and that there was no order for Depakote. RNS #1 verbalized that he/she reviewed Resident #1's diagnoses which included Seizure Disorder. During an interview on 11/12/2021 at 11:22 AM, the Director of Nursing (DON) stated that the facility's protocol for admissions is for the Registered Nurse Supervisors to obtain the PRI and Hospital Discharge Summary on a resident's admission to the facility. The RNS should review the PRI and Hospital Discharge Summary and inform and verify the discharge orders and recommendations with the Physician. The RNS then places the orders in the Sigma system. The DON said that RNS #1 placed Resident #1's orders in the Sigma but it was incomplete. The DON said that the Physicians are supposed to follow up in the morning after a resident's admission to the facility. The PRI is scanned in Sigma and the Discharge Summary is placed in the Nursing Office or on the unit where the resident is admitted . The DON stated that he/she did not know where Resident #1's Hospital Discharge Summary was placed. The DON verbalized that RN #1 should have informed the following shift about the emergency room Discharge Summary of 10/12/2021. The Physician should have spoken to the supervisor, follow up and should have insisted on getting Resident #1's emergency room Discharge Summary of 10/12/2021 since Resident #1 had seizures. The DON added that there was a breakdown in communication. The DON further added that he/she was not aware that the emergency room Discharge Summary was found in Resident #1's room until 10/26/2021 during a meeting with the Group Home. During an interview on 11/19/2021 at 1:00 PM, the Medical Director stated that around 10/20/2021, he/she became aware that Resident #1's Hospital Discharge order for Valproic Acid was not ordered by Resident #1's Attending Physician and that Resident #1 was transferred to the hospital with seizures. The Medical Director said that the admission procedure that Resident #1's Attending Physicians should have followed was to review the Hospital Discharge Summary and Instructions then reconciled the orders with the Registered Nurse. 415.11

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39170 Based on record review and staff interviews conducted during an abbreviated survey (NY00285166) on 11/03/2021, the facility staff did not ensure that a resident assessment accurately reflected the resident's cognitive patterns. This was evident in 1 out of 3 residents sampled (Resident #1). Specifically, the Minimum Data Set (MDS, a resident assessment tool) dated 10/08/2020 documented that Resident #1's long/short-term memory were okay. Record review revealed that Resident #1 was non-verbal, confused, and disoriented. The findings are: Review of the facility's undated policy and procedure on MDS documented: All staff members responsible for completion of the MDS receive training on the assessment, data entry and transmission process, in accordance with the MDS Resident Assessment Instrument (RAI) Instruction Manual, before being permitted to use the MDS information system. Only personnel authorized to complete portions of the MDS shall have access to the MDS information system. The MDS Coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking. Resident #1 was initially admitted to the facility on [DATE] with diagnoses including Autism, Seizure Disorder and Cerebral Palsy. A Nursing Correction Progress Note dated 10/01/2021 at 10:15 PM documented that Resident #1 was admitted from hospital at about 8:55 PM. On assessment Resident #1 was non-verbal, confused, and disoriented. A Cognitive Loss Care Plan as evidenced by long/short-term memory deficit was initiated on 10/04/2021. The interventions documented to provide supportive and therapeutic environment. To orient the resident to new surroundings and staff to explain procedures prior to starting. A Social Services New Admit Progress Note dated 10/04/2021 at 9:30 AM documented that Resident #1 could not be interviewed due to impaired cognition. Resident #1 was disoriented, non-verbal and unable to state needs to staff. Resident #1 was disoriented to self, surroundings, date, place, and time. The Minimum Data Set (MDS, a resident assessment tool) dated 10/08/2021, section C, documented that Resident #1 short-term memory was okay (resident seemed or appeared to recall after 5 minutes) and that Resident #1's long-term was okay (resident seemed or appeared to recall long past). Resident #1 was severely impaired for decision-making ability. Review of the MDS revealed that Resident #1's assessment of cognitive patterns was not accurately documented. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/10/2021 at 2:57 PM, the Social Worker (SW) stated that he/she completed Section C of Resident #1's MDS dated [DATE]. The SW stated that he/she made a mistake and coded the MDS incorrectly. The MDS coded that Resident #1's long/short-term were okay. The SW stated that the MDS should have coded that Resident #1 had long/short-term memory problems. During an interview on 11/15/2021 at 10:35 AM, the MDS Coordinator stated that he/she was responsible to see that all sections of the MDS were completed. The MDS Coordinator verbalized that he/she was not responsible for the accuracy of the MDS in the facility. The MDS Coordinator also said that each department was responsible for the completion of their sections and the SW completed Section C of Resident #1's MDS dated [DATE]. 415.11 (b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39170 Based on observations, interviews and record review conducted during an abbreviated survey (NY00285166) on 11/03/2021, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. This was evident in 1 out of 4 residents sampled (Resident #1). Specifically, Resident #1 was admitted from the hospital to the facility on [DATE] with discharge orders for Valproic Acid (Seizure medication). The Registered Nurse Supervisor (RNS) #1, who admitted Resident #1, did not communicate the Hospital discharged Orders to the Physician. Resident #1 had two (2) Seizures and was transferred to the hospital on 10/11/2021. Resident #1 was admitted back to the facility on [DATE] with instructions for Resident #1 to be started on Valproic Acid for Seizure. Registered Nurse (RN) #1 and the Physician, who admitted Resident #1 on 10/12/2021, did not review the emergency room Discharge instructions and medication orders. The Seizure medication was not ordered again for Resident #1. Resident #1 suffered another Seizure on 10/17/2021 and was transferred to the hospital. Resident #1 was admitted back to the facility with orders for Depakene Syrup (Valproic Acid) 1125mg every 12 hours. Resident #1 missed 16 days (32 dosages) of Seizure medication, suffered Seizures, and two hospital transfers before facility staff became aware that the hospital and emergency room Discharge Orders, for Valproic Acid, were not implemented. The findings are: Review of the facility's policy and procedure entitled Admissions, Transfers and Discharges last revised in April 2019 documented: The facility will admit only those residents whose, medical and nursing care needs can be met. Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least: type of diet, medication orders and routine care orders. Residents will be admitted to the facility if their nursing and medical needs can be met adequately by the facility. Potential residents with mental disorders or intellectual disabilities will only be admitted if the State Mental Health Agency has determined (through the pre-admission screening program) that the individual has a physical or mental condition that requires the level of services provided by the facility. A facility Summary of Investigation dated 10/26/2021 documented that the Valproic order for Resident #1 was missed on the initial admission on 10/01/2021. Resident #1 was transferred to the hospital on 10/11/2021 for evaluation of seizures. Resident #1 returned from Hospital on 10/12/2021 with recommendations to start Valproic Acid, Registered Nurse (RN) #1 did not review the emergency room (ER) discharged Paperwork and the Physician did not follow up on Resident #1's ER Discharge recommendations. The facility concluded that both the Nursing Supervisor and Resident #1's Attending Physician failed to locate the emergency room Discharge Summary upon Resident #1's return to the facility on [DATE]. The hospital recommendation for Resident #1 to start Valproic Acid was not followed. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was initially admitted to the facility on [DATE] with diagnoses including Autism, Seizure Disorder and Cerebral Palsy. The Minimum Data Set (MDS, a resident assessment tool) dated 10/08/2021 documented that Resident #1 had intact long/short-term memory and had severely impaired decision-making ability. Resident #1 previously resided in a Group Home prior to his/her hospitalization and admission to the facility. A Hospital Inpatient Discharge Summary dated 09/26/2021 documented: Reason for Admission: Small Bowel Obstruction, Septic Shock, and Pneumonia. History included Autism, Seizure Disorder, History of Aspiration Pneumonia, and Mental Disability (Cerebral Palsy). The Active Medication List included Valproate Sodium 500 mg in Dextrose 5% 50ml IVPB (intravenous piggyback), 500 mg 50/ml/hr. IV Q6H. (Home medications included Valproate 1125mg every 12 hours). A Nursing Correction Progress Note dated 10/01/2021 at 10:15 PM documented that Resident #1 was admitted from the hospital at about 8:55 PM accompanied by 2 Emergency Medical Service (EMS). Resident #1 had Past Medical History (PMHX) of Autism, Seizure, History of Aspiration, Mental Disability, Cataracts, Dysphagia, Non-Alcoholic Fatty Liver Disease (NAFLD) and Raynaud's Disease. On assessment Resident #1 was non-verbal, confused, and disoriented. A Physician's Order Activity Detail Report for 10/01/2021 and 10/02/2021, revealed that there was no order for Valproate Sodium medication. A Medical Correction Comprehensive Physician Admission Note dated 10/02/2021 at 7:34 AM documented that Resident #1 was discharged from hospital on 10/01/2021. All hospital paperwork reviewed. Medications included Lorazepam 2mg, give 2 tabs (4mg) by PEG every 6 hours for 15 days as needed for Anxiety, Clonazepam 0.5mg tablet, give 1 tablet by Percutaneous Endoscopic Gastrostomy (PEG) 2 times a day for 14 days as needed for anxiety. Listed diagnoses included Seizure Disorder. There was no mention of Valproic Acid for Seizure Disorder. A Nursing Progress Note dated 10/11/2021 at 9:35 PM documented that Resident #1 was observed with seizure activity twice. The seizures lasted 2 to 3 minutes. The Physician was notified and ordered to transfer Resident #1 to the hospital and 911 was called. Resident #1 left the facility via Emergency Medical Service (EMS) at 9:00 PM. The emergency room Discharge Summary (ERDS) dated 10/12/2021 documented Valproate Level collected 10/11/2021 at 10:50 PM. The result documented that Resident #1's Valproic Acid level was <20.0ug/ml (reference range 50.0-140.0ug/ml). The discharge summary documented Patient was supposed to be on Depakene syrup 1125mg every 12 hours, however this was not listed in the Nursing Home medications. Resident #1 presented to the Emergency Department (ED) on 10/11/20221 with two witnessed convulsive seizures at the nursing home. The Valproic Acid level found to be subtherapeutic. It was likely that the resident was not getting the scheduled doses at the Nursing Home. Resident #1 was observed to have myoclonic jerks on presentation to the ED. Restart Valproic Acid 1125mg two times a day (Depakene syrup through the PEG tube). A Nursing Progress Note dated 10/12/2021 at 7:16 PM documented that Resident #1 had returned from the hospital at 5:00 PM. Resident #1 was in stable condition. The tube feeding was completed, and medication given via gastrostomy (GT). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335744	A. Building B. Wing	11/19/2021

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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation that the physician was notified of Resident #1's return to the facility. There was no documentation that the discharge summary was reviewed and there was no mention of Valproic Acid. A Physician's Order Activity Detail Report for 10/12/2021 revealed that there was no order for Valproic Acid/Depakote. A Physician's Progress Note dated 10/15/2021 at 6:32 AM documented that Resident #1 was seen at the bedside. Chief Complaint (CC): follow up of Infection. The physician's progress note did not mention the hospital recommendation to start Resident #1 on Valproic Acid for Seizure Disorder. A Nursing Progress Note dated 10/17/2021 documented that at about 5:20 AM, Resident #1 was observed by private caregiver with seizure activity. The caregiver described it as sudden, jerky and shaking movement which lasted about 1 minute. On assessment, Resident #1 was back to baseline. The Physician was notified and recommended transfer to the hospital for evaluation. A Physician's Order dated 10/17/2021 at 3:15 PM documented Valproic Acid (as sodium salt) 250mg/5ml oral solution, give 22.5mls (1125mg) by PEG tube route every 12 hours. A Nursing Progress Note dated 10/17/2021 at 3:24 PM documented that Resident #1 returned from hospital at approximately 1:12 PM via stretcher accompanied by 2 Emergency Medical Technicians. The resident was alert and responsive, in no distress. New order for Depakene 1,125mg ordered. The Physician was notified, and the medication transcribed in Medication Administration Record (MAR). A Review of the Medication Administration Record (MAR) dated 10/18/2021 documented that Valproic Acid 1125mg by PEG tube every 12 hours was administered on 10/18/2021 at 9:00 AM. A Nursing Progress Note (late entry for 10/12/2021) dated 10/20/2021 at 4:47 PM documented no new medical order received by writer upon Resident #1's return from the hospital. A Physician's Progress Note dated 10/20/2021 at 6:19 AM documented that Resident #1 was seen at the bedside. There was no documentation of the discharge summary or the Seizure medication. During an interview on 11/03/2021 at 1:30 PM, the Mental Hygiene Nurse Program Coordinator from New York State Developmental Disabilities Office stated that on 10/17/2021, he/she received a call from the Hospital Physician regarding Resident #1. The Hospital Physician informed the Nurse Program Coordinator that Resident #1 was in the emergency room and the level of Resident #1's seizure medication was zero. The Nurse Program Coordinator further stated that he/she assigned a Group Home Registered Nurse (GHRN) to go to the facility to see Resident #1. The Nurse Program Coordinator added that the GHRN stated that he/she observed Resident #1's hospital discharge papers on the bedside table in Resident #1's room. The Nurse Program Coordinator added that he/she request a meeting and a plan of correction from the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/03/2021 at 1:40 PM, the GHRN stated that he/she went to the facility on [DATE] to reconcile Resident #1's medications around 3:00 PM. The GHRN stated that he/she requested a printout of Resident #1's medications from the charge nurse. The printout showed that Resident #1's medications did not include Valproic Acid. The GHRN went to Resident #1's room and observed the hospital discharge papers dated 10/12/2021 on Resident #1's bedside table. The GHRN stated that a companion was with Resident #1 in the room and stated that the discharge papers were in Resident #1's room. The GHRN stated that he/she went to the nurse and alerted him/her about the finding of the hospital discharge summary. The GHRN added that the facility entered the Valproic Acid medication order for Resident #1 after 3:00 PM on 10/17/2021, while he/she was onsite at the facility. During an interview on 11/03/2021 at 2:30 PM, Registered Nurse Supervisor #2 (RNS #2) stated that he/she was covering Resident #1's unit on 10/02/2021. RNS #2 stated that he/she did not review Resident #1's admission orders and Resident #1's hospital discharge summary. RNS #2 stated that he/she did not admit Resident #1, and he/she was not responsible for reviewing Resident #1's admission orders and hospital discharge summary on the following day after Resident #1's admission to the facility. During an interview on 11/03/2021 and 11/19/2021, RN #1 stated that he/she worked as the Nursing Supervisor when Resident #1 was transferred to the hospital on 10/11/2021 and when Resident #1 returned from the hospital on 10/12/2021. RN #1 verbalized that when he/she worked as a Nursing Supervisor, his/her responsibility included checking Resident #1's Hospital Discharge Summary or emergency room Discharge Summary to see if there were any new orders and to notify the Physician. RN #1 said that he/she asked Resident #1's companion about the hospital discharge papers but the companion told him/her that Resident #1 had no discharge papers. RN #1 said that he/she checked Resident #1's diagnoses and medications but could not remember if he/she had seen Resident #1's Seizure Disorder diagnosis and or that Resident #1 had medication for Seizure Disorder. RN #1 also said that he/she called the hospital but did not reach anyone. RN #1 further stated he/she did not ask the incoming shift to follow up with the hospital and that he/she did not notify the DON. During an interview on 11/04/2021 at 1:06 PM, RNS #3 stated that he/she reconciled Resident #1's medications with the Physician on 10/17/2021 when Resident #1 returned from the emergency room (ER). RNS #3 stated that he/she received the emergency room Discharge recommendations from the Emergency Medical Technician (EMT). RNS #3 stated that he/she could not recall having any interaction with the GHRN regarding Resident #1's medications. During an interview on 11/04/2021 at 1:50 PM, Registered Nurse Supervisor #1 (RNS #1) stated that he/she was the Nursing Supervisor for the night shift on 10/01/2021 and performed Resident #1's admission assessment. RNS #1 said that he/she reviewed the PRI and entered the orders in the Electronic Medical Record (EMR) then notified the Physician. RNS #1 said that he/she was not sure if there was a Hospital Discharge Summary for Resident #1 on 10/01/2021 and that there was no order for Depakote. RNS #1 verbalized that he/she reviewed Resident #1's diagnoses which included Seizure Disorder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/12/2021 at 11:22 AM, the Director of Nursing (DON) stated that the facility's protocol for admissions is for the Registered Nurse Supervisors to obtain the PRI and Hospital Discharge Summary on a resident's admission to the facility. The RNS should review the PRI and Hospital Discharge Summary and inform and verify the discharge orders and recommendations with the Physician. The RNS then places the orders in the Sigma system. The DON said that RNS #1 placed Resident #1's orders in Sigma but it was incomplete. The DON said that the Physicians are supposed to follow up in the morning after a resident's admission to the facility. The PRI is scanned in Sigma and the Discharge Summary is placed in the Nursing Office or on the unit where the resident is admitted . The DON stated that he/she did not know where Resident #1's Hospital Discharge Summary was placed. The DON verbalized that RN #1 should have informed the following shift about the emergency room Discharge Summary of 10/12/2021. The Physician should have spoken to the supervisor, follow up and should have insisted on getting Resident #1's emergency room Discharge Summary of 10/12/2021 since Resident #1 had seizures. The DON added that there was a breakdown in communication. The DON further added that he/she was not aware that the emergency room Discharge Summary was found in Resident #1's room until 10/26/2021 during a meeting with the Group Home. 415.12