Printed: 11/20/2024 Form Approved OMB No. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335744	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2021	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact the nursing home or the state survey a	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
F 0635	Provide doctor's orders for the resi	dent's immediate care at the time the r	esident was admitted.	
Level of Harm - Actual harm	**NOTE- TERMS IN BRACKETS H	AVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 39170	
Residents Affected - Few	 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 discharge orders from the ER for Depakene (Valproic Acid) Syrup 1125 mg every thours. 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 fo the immediate care of the resident, including orders covering at least: type of diet, medication orders and routine care orders.			
	for Resident #1 that was missed or hospital on 10/11/2021 for evaluati recommendations to start Valproic Discharge Paperwork and the Phys The facility concluded that both the locate the emergency room Discha	mary of Investigation dated 10/26/2021 documented that there was an order for Valproic / 1 that was missed on the initial admission on 10/01/2021. Resident #1 was transferred to /11/2021 for evaluation of seizures. Resident #1 returned from Hospital on 10/12/2021 wi ions to start Valproic Acid, Registered Nurse (RN) #1 did not review the emergency room perwork and the Physician did not follow up on Resident #1's ER Discharge recommenda ncluded that both the Nursing Supervisor and Resident #1's Attending Physician failed to ergency room Discharge Summary upon Resident #1's return to the facility on [DATE]. The mendation for Resident #1 to start Valproic Acid was not followed.		
	(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

Facility ID: 335744

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NAME OF PROVIDER OR SUPPLIER Grand Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 700 White Plains Road Bronx, NY 10473	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	 tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
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 Disord 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-makin ability. Resident #1 previously resided in a Group Home prior to his/her hospitalization and admission to the facility.		
	Bowel Obstruction, Septic Shock, a Aspiration Pneumonia, and Mental	nmary dated 09/26/2021 documented: and Pneumonia. History included Autist Disability (Cerebral Palsy). The Active ml IVPB (intravenous piggyback), 500 25mg every 12 hours).	n, Seizure Disorder, History of Medication List included Valproate
	A Nursing Correction Progress Note dated 10/01/2021 at 10:15 PM documented that Re admitted from the hospital at about 8:55 PM accompanied by 2 Emergency Medical Serv #1 had Past Medical History (PMHX) of Autism, Seizure, History of Aspiration, Mental Di Dysphagia, Non-Alcoholic Fatty Liver Disease (NAFLD) and Raynaud's Disease. On ass #1 was non-verbal, confused, and disoriented.		cy Medical Service (EMS). Residen ition, Mental Disability, Cataracts,
	A Physician's Order Activity Detail for Valproate Sodium medication.	Report for 10/01/2021 and 10/02/2021,	revealed that there was no order
	A Neurological Function with Risk for Seizure related to Seizure Disorder Care Plan was initiated 10/02/2021. The interventions included administer medications as ordered, observed for side effectiveness, and observe for change in mental status.		
	that Resident #1 was discharged fr included Lorazepam 2mg, give 2 ta Clonazepam 0.5mg tablet, give 1 ta	ive Physician Admission Note dated 10 om hospital on 10/01/2021. All hospita lbs (4mg) by PEG every 6 hours for 15 ablet by Percutaneous Endoscopic Gas ed diagnoses included Seizure Disorde	l paperwork reviewed. Medications days as needed for Anxiety, strostomy (PEG) 2 times a day for
	seizure activity twice. The seizures	11/2021 at 9:35 PM documented that I lasted 2 to 3 minutes. The Physician v ospital. Resident #1 left the facility via	vas notified and ordered that
	on 10/11/2021 at 10:50 PM. The re (reference range 50.0-140.0ug/ml). Depakene Syrup 1125mg every 12 Resident #1 presented to the Emer seizures at the nursing home. The resident was not getting the schedu	ummary (ERDS) dated 10/12/2021 doc sult documented that Resident #1's Va . The discharge summary documented hours, however this was not listed in t rgency Department (ED) on 10/11/2022 Valproic Acid level found to be subther uled doses at the Nursing Home. Resid the ED. Restart Valproic Acid 1125mg	Alproic Acid level was <20.0ug/ml Patient was supposed to be on the Nursing Home medications. 21 with two witnessed convulsive apeutic. It was likely that the lent #1 was observed to have
	(continued on next page)		

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Grand Manor Nursing & Rehabilitation Center		700 White Plains Road Bronx, NY 10473	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0635 Level of Harm - Actual harm	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).		
Residents Affected - Few		he physician was notified of Resident # je summary was reviewed and there w	
	A Physician's Order Activity Detail Acid/Depakote.	Report for 10/12/2021 revealed that the	ere was no order for Valproic
	A Physician's Progress Note dated 10/15/2021 at 6:32 AM documented that Resident #1 was bedside. Chief Complaint (CC): follow up of Infection.		nat Resident #1 was seen at the
The physician's progress note did not mention the hospital recommendation for Seizure Disorder.		not mention the hospital recommendati	on to start Resident #1 on Valproid
	by private caregiver with seizure ac	17/2021 documented that at about 5:2 stivity. The caregiver described it as successment, Resident #1 was back to ba nospital for evaluation.	dden, jerky and shaking movemer
)21 at 3:15 PM documented Valproic A g) by PEG tube route every 12 hours.	cid (as sodium salt) 250mg/5ml
	at approximately 1:12 PM via streto was alert and responsive, in no dis	17/2021 at 3:24 PM documented that f ther accompanied by 2 Emergency Me tress. New order for Depakene 1,125m ibed in Medication Administration Reco	dical Technicians. The resident g ordered. The Physician was
		stration Record (MAR) dated 10/18/20 rrs was administered on 10/18/2021 at	•
	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.		
		10/20/2021 at 6:19 AM documented th tion of the discharge summary or the S	
	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.		
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F 0635 Level of Harm - Actual harm Residents Affected - Few	York State Developmental Disabiliti Hospital Physician regarding Resid that Resident #1 was in the emerge The Nurse Program Coordinator fur (GHRN) to go to the facility to see If stated that he/she observed Reside room. The Nurse Program Coordina the facility. During an interview on 11/03/2021 reconcile Resident #1's medication Resident #1's medications from the not include Valproic Acid. The GHF papers dated 10/12/2021 on Reside Resident #1 in the room and stated that he/she went to the nurse and a GHRN added that the facility entered 10/17/2021, while he/she was onsit During an interview on 11/03/2021 was the Physician who admitted Re reviewed the Patient Review Instru- the same night of Resident #1's adi for the Valproic Acid when he/she r Attending Physician stated that he/ was not sure if Resident #1 was on that he/she was informed that Resi- transferred to the ER for evaluation Discharge Summary for 10/12/2021 that he/she asked the unit nurse and and instructed them to call the hosp state the names of the staff who he Physician also said that he/she call he/she did not get to speak to anyon	at 1:30 PM, the Mental Hygiene Nurse es Office stated that on 10/17/2021, he ent #1. The Hospital Physician informe ency room and the level of Resident #1 rther stated that he/she assigned a Gro Resident #1. The Nurse Program Coord ent #1's hospital discharge papers on the ator added that he/she request a meeti at 1:40 PM, the GHRN stated that he/s is around 3:00 PM. The GHRN stated the charge nurse. The printout showed that the charge nurse. The printout showed that the discharge papers were in Resident #1's room and obs ent #1's bedside table. The GHRN stated that the discharge papers were in Resident #1's bedside table. The GHRN stated that the discharge papers were in Resident #1 on 10/01/2021. The Attending of the Valproic Acid medication order for e at the facility. and 11/18/2021, Resident #1's Attending sident #1 on 10/01/2021. The Attending ment (PRI), Resident #1's history and t mission. The Attending Physician verbate eviewed Resident #1's hospital dischar she was aware that Resident #1's had any medications for the Seizure Disord dent #1 had Seizures on 10/11/2021 ar . The Attending Physician said that he/ I after Resident #1 returned to the facil d the nursing supervisor for Resident # oital for the discharge summary. The Attending Physician stated that she asked for Resident #1's Hospital I ed the hospital for Resident #1's Disch ne. The Attending Physician stated tha of Nursing (DON) regarding Resident #	Algorithms and a stated that helps and a stated that h

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F 0635 Level of Harm - Actual harm Residents Affected - Few	Supervisor when Resident #1 was from the hospital on 10/12/2021. R but could not remember if he/she h had medication for Seizure Disorder his/her responsibility included chect Discharge Summary to see if there asked Resident #1's companion ab Resident #1 had no discharge pape anyone. RN #1 further stated he/sh he/she did not notify the DON. During an interview on 11/04/2021 was the Nursing Supervisor for the assessment. RNS #1 said that he/s Record (EMR) then notified the Phy Discharge Summary for Resident # verbalized that he/she reviewed Re During an interview on 11/12/2021 protocol for admissions is for the R Summary on a resident's admission Summary and inform and verify the then places the orders in the Sigma Sigma but it was incomplete. The D after a resident's admission to the f placed in the Nursing Office or on t not know where Resident #1's Hos should have informed the following Physician should have spoken to the emergency room Discharge Summ there was a breakdown in commune emergency room Discharge Summ with the Group Home. During an interview on 11/19/2021 became aware that Resident #1's F #1's Attending Physician and that F Director said that the admission pro-	and 11/19/2021, RN #1 stated that he/ transferred to the hospital on 10/11/202 N #1 said that he/she checked Resider ad seen Resident #1's Seizure Disorde er. RN #1 verbalized that when he/she is king Resident #1's Hospital Discharge were any new orders and to notify the pout the hospital discharge papers but the rest. RN #1 also said that he/she called the did not ask the incoming shift to follow at 1:50 PM, Registered Nurse Supervis inght shift on 10/01/2021 and performed she reviewed the PRI and entered the of ysician. RNS #1 said that he/she was no esident #1's diagnoses which included at at 11:22 AM, the Director of Nursing (If egistered Nurse Supervisors to obtain in to the facility. The RNS should review e discharge orders and recommendation a system. The DON said that RNS #1 p DON said that the Physicians are suppor facility. The PRI is scanned in Sigma an he unit where the resident is admitted pital Discharge Summary was placed is shift about the emergency room Disch the supervisor, follow up and should hav ary of 10/12/2021 since Resident #1 ha ication. The DON further added that he ary was found in Resident #1's room u at 1:00 PM, the Medical Director stated dospital Discharge order for Valproic A Resident #1 was transferred to the hosp ocedure that Resident #1's Attending P ge Summary and Instructions then reco	21 and when Resident #1 returned at #1's diagnoses and medications ar diagnosis and that Resident #1 worked as a Nursing Supervisor, Summary or emergency room Physician. RN #1 said that he/she he companion told RN #1 that the hospital but did not reach w up with the hospital and that sor #1 (RNS #1) stated that he/she ed Resident #1's admission orders in the Electronic Medical tot sure if there was a Hospital o order for Depakote. RNS #1 Seizure Disorder. DON) stated that the facility's the PRI and Hospital Discharge <i>y</i> the DON stated that he/she did The DON stated that he/she did The DON stated that he/she did The DON verbalized that RN #1 arge Summary of 10/12/2021. The <i>y</i> insisted on getting Resident #1's ad seizures. The DON added that <i>y</i> /she was not aware that the ntil 10/26/2021 during a meeting d that around 10/20/2021, he/she cid was not ordered by Resident bital with seizures. The Medical hysicians should have followed

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F 0641	Ensure each resident receives an a	accurate assessment.	
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 39170
Residents Affected - Few	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 Minimu 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, a 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 assessmer transmission process, in accordance with the MDS Resident Assessment Instrument (RAI) Manual, before being permitted to use the MDS information system. Only personnel author portions of the MDS shall have access to the MDS information system. The MDS Coordina for ensuring that appropriate edits are made prior to transmitting MDS data and that feedba reports from each transmission are maintained for historical purposes and for tracking.		Instrument (RAI) Instruction personnel authorized to complete ne MDS Coordinator is responsible a and that feedback and validation
	Resident #1 was initially admitted to and Cerebral Palsy.	o the facility on [DATE] with diagnoses	including Autism, Seizure Disorde
		e dated 10/01/2021 at 10:15 PM docur 5 PM. On assessment Resident #1 wa	
		lenced by long/short-term memory defi rovide supportive and therapeutic envi ain 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 R documented.	tesident #1's assessment of cognitive p	patterns was not accurately
	(continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/10/2021 C of Resident #1's MDS dated [DA incorrectly. The MDS coded that Re should have coded that Resident # During an interview on 11/15/2021 see that all sections of the MDS we responsible for the accuracy of the	full regulatory or LSC identifying informati at 2:57 PM, the Social Worker (SW) st TE]. The SW stated that he/she made esident #1's long/short-term were okay 1 had long/short-term memory problem at 10:35 AM, the MDS Coordinator sta ere completed. The MDS Coordinator v MDS in the facility. The MDS Coordina of their sections and the SW complete	ated that he/she completed Section a mistake and coded the MDS . The SW stated that the MDS ns. ted that he/she was responsible to rerbalized that he/she was not ator also said that each department

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	 **NOTE- TERMS IN BRACKETS H Based on observations, interviews (NY00285166) on 11/03/2021, the accordance with professional stand was evident in 1 out of 4 residents hospital to the facility on [DATE] wi Registered Nurse Supervisor (RNS discharged Orders to the Physician 10/11/2021. Resident #1 was admi started on Valproic Acid for Seizure on 10/12/2021, did not review the e Seizure medication was not ordere 10/17/2021 and was transferred to Depakene Syrup (Valproic Acid) 11 Seizure medication, suffered Seizu hospital and emergency room Disc The findings are: Review of the facility's policy and p April 2019 documented: The facility will admit only those rest the time of admission, the resident' the immediate care of the resident, routine care orders. Residents will adequately by the facility. Potential admitted if the State Mental Health that the individual has a physical or A facility Summary of Investigation was missed on the initial admissior 10/11/2021 for evaluation of seizur recommendations to start Valproic discharged Paperwork and the Phy recommendations. The facility cond Physician failed to locate the emergen (State State Mental Health) 	care according to orders, resident's pre- AVE BEEN EDITED TO PROTECT CO and record review conducted during ar facility did not ensure that residents red lards of practice and the comprehensiv sampled (Resident #1). Specifically, Re th discharge orders for Valproic Acid (S b) #1, who admitted Resident #1, did no not the back to the facility on [DATE] with a Registered Nurse (RN) #1 and the Pl progregency room Discharge instructions d again for Resident #1. Resident #1 so the hospital. Resident #1 was admitted (25mg every 12 hours. Resident #1 mis res, and two hospital transfers before f harge Orders, for Valproic Acid, were r rocedure entitled Admissions, Transfer sidents whose, medical and nursing car s Attending Physician must provide the including orders covering at least: type be admitted to the facility if their nursing residents with mental disorders or inte Agency has determined (through the p r mental condition that requires the leve dated 10/26/2021 documented that the of on 10/01/2021. Resident #1 was trans es. Resident #1 returned from Hospital Acid, Registered Nurse (RN) #1 did no rsician did not follow up on Resident #1 cluded that both the Nursing Supervisor gency room Discharge Summary upon idation for Resident #1 to start Valproic	DNFIDENTIALITY** 39170 a abbreviated survey seive treatment and care in e person-centered care plan. This asident #1 was admitted from the Seizure medication). The ot communicate the Hospital d was transferred to the hospital on instructions for Resident #1 to be hysician, who admitted Resident #1 and medication orders. The uffered another Seizure on I back to the facility with orders for ssed 16 days (32 dosages) of acility staff became aware that the hot implemented. Is and Discharges last revised in re needs can be met. Prior to or at a facility with information needed for e of diet, medication orders and g and medical needs can be met llectual disabilities will only be re-admission screening program) el of services provided by the facility e Valproic order for Resident #1 sferred to the hospital on on 10/12/2021 with t review the emergency room (ER) 's ER Discharge r and Resident #1's return to the facility

SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by Resident #1 was initially admitted to and Cerebral Palsy. The Minimum I documented that Resident #1 had i ability. Resident #1 previously resid	full regulatory or LSC identifying informati o the facility on [DATE] with diagnoses Data Set (MDS, a resident assessment	agency. on)
on Center an to correct this deficiency, please cont SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by the Resident #1 was initially admitted to and Cerebral Palsy. The Minimum I documented that Resident #1 had i ability. Resident #1 previously resid	700 White Plains Road Bronx, NY 10473 act the nursing home or the state survey a IENCIES full regulatory or LSC identifying information to the facility on [DATE] with diagnoses Data Set (MDS, a resident assessment	agency. on)
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Resident #1 was initially admitted to the facility on [DATE] with diagnoses including Autism, Seizure Disor 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-mal ability. Resident #1 previously resided in a Group Home prior to his/her hospitalization and admission to t facility.		
 A Hospital Inpatient Discharge Summary dated 09/26/2021 documented: Reason for Admis Bowel Obstruction, Septic Shock, and Pneumonia. History included Autism, Seizure Disord Aspiration Pneumonia, and Mental Disability (Cerebral Palsy). The Active Medication List in Sodium 500 mg in Dextrose 5% 50ml IVPB (intravenous piggyback), 500 mg 50/ml/hr. IV C medications included Valproate 1125mg every 12 hours). A Nursing Correction Progress Note dated 10/01/2021 at 10:15 PM documented that Resid admitted from the hospital at about 8:55 PM accompanied by 2 Emergency Medical Service #1 had Past Medical History (PMHX) of Autism, Seizure, History of Aspiration, Mental Disa Dysphagia, Non-Alcoholic Fatty Liver Disease (NAFLD) and Raynaud's Disease. On asses #1 was non-verbal, confused, and disoriented. 		n, Seizure Disorder, History of Medication List included Valproate
		y Medical Service (EMS). Resident tion, Mental Disability, Cataracts,
A Physician's Order Activity Detail F for Valproate Sodium medication.	Report for 10/01/2021 and 10/02/2021,	revealed that there was no order
A Medical Correction Comprehensive Physician Admission Note dated 10/02/2021 at 7:34 AM that Resident #1 was discharged from hospital on 10/01/2021. All hospital paperwork reviewed included Lorazepam 2mg, give 2 tabs (4mg) by PEG every 6 hours for 15 days as needed for A Clonazepam 0.5mg tablet, give 1 tablet by Percutaneous Endoscopic Gastrostomy (PEG) 2 tim 14 days as needed for anxiety. Listed diagnoses included Seizure Disorder. There was no men		paperwork reviewed. Medications days as needed for Anxiety, strostomy (PEG) 2 times a day for
seizure activity twice. The seizures	lasted 2 to 3 minutes. The Physician w	as notified and ordered to transfer
10/11/2021 at 10:50 PM. The result (reference range 50.0-140.0ug/ml). Depakene syrup 1125mg every 12 Resident #1 presented to the Emer seizures at the nursing home. The resident was not getting the schedu	documented that Resident #1's Valpro The discharge summary documented hours, however this was not listed in th gency Department (ED) on 10/11/2022 Valproic Acid level found to be subther- iled doses at the Nursing Home. Resid	bic Acid level was <20.0ug/ml Patient was supposed to be on the Nursing Home medications. If with two witnessed convulsive apeutic. It was likely that the ent #1 was observed to have
hospital at 5:00 PM. Resident #1 wa given via gastrostomy (GT).		
	Aspiration Pneumonia, and Mental Sodium 500 mg in Dextrose 5% 500 medications included Valproate 112 A Nursing Correction Progress Note admitted from the hospital at about #1 had Past Medical History (PMH) Dysphagia, Non-Alcoholic Fatty Liv #1 was non-verbal, confused, and of A Physician's Order Activity Detail F for Valproate Sodium medication. A Medical Correction Comprehensit that Resident #1 was discharged fro included Lorazepam 2mg, give 2 ta Clonazepam 0.5mg tablet, give 1 ta 14 days as needed for anxiety. Listo Valproic Acid for Seizure Disorder. A Nursing Progress Note dated 10/ seizure activity twice. The seizures Resident #1 to the hospital and 911 (EMS) at 9:00 PM. The emergency room Discharge Su 10/11/2021 at 10:50 PM. The result (reference range 50.0-140.0ug/ml). Depakene syrup 1125mg every 12 Resident #1 presented to the Emer seizures at the nursing home. The V resident was not getting the schedu myoclonic jerks on presentation to through the PEG tube). A Nursing Progress Note dated 10/ hospital at 5:00 PM. Resident #1 was	 Aspiration Pneumonia, and Mental Disability (Cerebral Palsy). The Active Sodium 500 mg in Dextrose 5% 50ml IVPB (intravenous piggyback), 500 medications included Valproate 1125mg every 12 hours). A Nursing Correction Progress Note dated 10/01/2021 at 10:15 PM docum admitted from the hospital at about 8:55 PM accompanied by 2 Emergenous #1 had Past Medical History (PMHX) of Autism, Seizure, History of Aspira Dysphagia, Non-Alcoholic Fatty Liver Disease (NAFLD) and Raynaud's Di #1 was non-verbal, confused, and disoriented. A Physician's Order Activity Detail Report for 10/01/2021 at 10/02/2021, for Valproate Sodium medication. A Medical Correction Comprehensive Physician Admission Note dated 100 that Resident #1 was discharged from hospital on 10/01/2021. All hospital included Lorazepam 2mg, give 2 tabs (4mg) by PEG every 6 hours for 15 Clonazepam 0.5mg tablet, give 1 tablet by Percutaneous Endoscopic Gas 14 days as needed for anxiety. Listed diagnoses included Seizure Disorder. A Nursing Progress Note dated 10/11/2021 at 9:35 PM documented that F seizure activity twice. The seizures lasted 2 to 3 minutes. The Physician w Resident #1 to the hospital and 911 was called. Resident #1 left the facility (EMS) at 9:00 PM. The emergency room Discharge Summary (ERDS) dated 10/12/2021 doc 10/11/2021 at 10:50 PM. The result documented that Resident #1's Valpro (reference range 50.0-140.0ug/ml). The discharge summary documented Depakene syrup 1125mg every 12 hours, however this was not listed in th Resident #1 presented to the Emergency Department (ED) on 10/11/2022 seizures at the nursing home. The Valproic Acid level found to be subther resident #1 presentation to the ED. Restart Valproic Acid 1125mg through the PEG tube). A Nursing Progress Note dated 10/12/2021 at 7:16 PM documented that F hospital at 5:00 PM. Resident #1 was in stable condition. The tube feeding given via gastrostomy (GT).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335744	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2021
NAME OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZI	P 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 cont	tact 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)		on)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	 no documentation that the discharg A Physician's Order Activity Detail F Acid/Depakote. A Physician's Progress Note dated bedside. Chief Complaint (CC): fold The physician's progress note did m Acid for Seizure Disorder. A Nursing Progress Note dated 10/ by private caregiver with seizure ac which lasted about 1 minute. On as and recommended transfer to the h A Physician's Order dated 10/17/20 oral solution, give 22.5mls (1125mg A Nursing Progress Note dated 10/ at approximately 1:12 PM via stretce was alert and responsive, in no dist notified, and the medication transcr A Review of the Medication Adminis 1125mg by PEG tube every 12 hou A Nursing Progress Note (late entry medical order received by writer up A Physician's Progress Note dated bedside. There was no documentated During an interview on 11/03/2021. York State Developmental Disabilitit Hospital Physician regarding Residi that Resident #1 was in the emerge The Nurse Program Coordinator fun (GHRN) to go to the facility to see F stated that he/she observed Reside 	not mention the hospital recommendati 17/2021 documented that at about 5:2 tivity. The caregiver described it as successment, Resident #1 was back to ba	as no mention of Valproic Acid. ere was no order for Valproic hat Resident #1 was seen at the on to start Resident #1 on Valproid 0 AM, Resident #1 was observed dden, jerky and shaking movemen aseline. The Physician was notified cid (as sodium salt) 250mg/5ml Resident #1 returned from hospital dical Technicians. The resident g ordered. The Physician was ord (MAR). 21 documented that Valproic Acid 9:00 AM. 4:47 PM documented no new tal. tat Resident #1 was seen at the eizure medication. Program Coordinator from New e/she received a call from the d the Nurse Program Coordinator 's seizure medication was zero. bup Home Registered Nurse dinator added that the GHRN he bedside table in Resident #1's

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NAME OF PROVIDER OR SUPPLIER Grand Manor Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 700 White Plains Road Bronx. NY 10473	P CODE
For information on the oursing home's	nian to correct this deficiency nlease con	tact the nursing home or the state survey	agency
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reconcile Resident #1's medication Resident #1's medications from the not include Valproic Acid. The GHF papers dated 10/12/2021 on Reside Resident #1 in the room and stated that he/she went to the nurse and a GHRN added that the facility enterer 10/17/2021, while he/she was onsit During an interview on 11/03/2021 was covering Resident #1's unit on admission orders and Resident #1' Resident #1, and he/she was not re discharge summary on the followin During an interview on 11/03/2021 Supervisor when Resident #1 was	at 1:40 PM, the GHRN stated that he/s s around 3:00 PM. The GHRN stated the charge nurse. The printout showed the RN went to Resident #1's room and obs ent #1's bedside table. The GHRN state I that the discharge papers were in Res alerted him/her about the finding of the ed the Valproic Acid medication order for the at the facility. at 2:30 PM, Registered Nurse Supervis 10/02/2021. RNS #2 stated that he/sh is hospital discharge summary. RNS #2 esponsible for reviewing Resident #1's g day after Resident #1's admission to and 11/19/2021, RN #1 stated that he/ transferred to the hospital on 10/11/202 N #1 verbalized that when he/she work	hat he/she requested a printout of at Resident #1's medications did served the hospital discharge ed that a companion was with sident #1's room. The GHRN stated hospital discharge summary. The or Resident #1 after 3:00 PM on sor #2 (RNS #2) stated that he/she e did not review Resident #1's e stated that he/she did not admit admission orders and hospital the facility. she worked as the Nursing 21 and when Resident #1 returned
	responsibility included checking Re Summary to see if there were any r Resident #1's companion about the #1 had no discharge papers. RN # could not remember if he/she had s had medication for Seizure Disorde anyone. RN #1 further stated he/sh he/she did not notify the DON. During an interview on 11/04/2021 medications with the Physician on	sident #1's Hospital Discharge Summa hew orders and to notify the Physician. hospital discharge papers but the con 1 said that he/she checked Resident #1's seen Resident #1's Seizure Disorder di er. RN #1 also said that he/she called the e did not ask the incoming shift to follo at 1:06 PM, RNS #3 stated that he/she 10/17/2021 when Resident #1 returned the emergency room Discharge recor	ary or emergency room Discharge RN #1 said that he/she asked hpanion told him/her that Resident I's diagnoses and medications but agnosis and or that Resident #1 he hospital but did not reach w up with the hospital and that e reconciled Resident #1's I from the emergency room (ER).
	Medical Technician (EMT). RNS #3 regarding Resident #1's medication During an interview on 11/04/2021 was the Nursing Supervisor for the	stated that he/she could not recall hav	ving any interaction with the GHRN sor #1 (RNS #1) stated that he/she ed Resident #1's admission
	Discharge Summary for Resident #	ysician. RNS #1 said that he/she was n 1 on 10/01/2021 and that there was no sident #1's diagnoses which included s	o order for Depakote. RNS #1

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		STREET ADDRESS, CITY, STATE, ZI 700 White Plains Road	P CODE
		Bronx, NY 10473	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protocol for admissions is for the R Summary on a resident's admission Summary and inform and verify the then places the orders in the Sigma Sigma but it was incomplete. The D after a resident's admission to the f placed in the Nursing Office or on t not know where Resident #1's Hos should have informed the following Physician should have spoken to th emergency room Discharge Summ there was a breakdown in commun	at 11:22 AM, the Director of Nursing (E egistered Nurse Supervisors to obtain in to the facility. The RNS should review e discharge orders and recommendation a system. The DON said that RNS #1 p DON said that the Physicians are support facility. The PRI is scanned in Sigma ar he unit where the resident is admitted . pital Discharge Summary was placed. shift about the emergency room Disch ne supervisor, follow up and should hav ary of 10/12/2021 since Resident #1 ha itication. The DON further added that he ary was found in Resident #1's room u	the PRI and Hospital Discharge to the PRI and Hospital Discharge ns with the Physician. The RNS blaced Resident #1's orders in osed to follow up in the morning nd the Discharge Summary is The DON stated that he/she did The DON verbalized that RN #1 arge Summary of 10/12/2021. The re insisted on getting Resident #1's ad seizures. The DON added that be/she was not aware that the