STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335340	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cottages at Garden Grove, A Skilled Nrsg Comm	5460 Meltzer Court Cicero, NY 13039

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 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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the abbreviated survey (iQIES #2643653) the facility did not ensure residents received treatment and care in accordance with professional standards of practice for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 did not receive timely treatment or interventions when they did not have bowel movements for more than three (3) days. Additionally, the medical provider was not notified of the resident's bowel status and when a bowel medication was not available to administer. Findings include:The facility's 03/2014 policy Bowel Protocol documented:- Certified nursing assistants would record the bowel movement of residents every shift on bowel movement worksheets.- Licensed nursing staff would monitor residents' bowel patterns by reviewing the bowel movement worksheet daily and apply the bowel protocol as ordered. - If a resident failed to have a bowel movement within three (3) days, by the evening of the third day, licensed nursing staff were to administer Milk of Magnesia at bedtime; on day four (4) additional medication, suppository and enema were to be given if the resident continued to have no bowel movements; on day five (5), clear liquid diet, notify the physician, and a registered nurse would complete a rectal exam to check for presence of stool but not to digitally remove stool. - If this protocol was ineffective, the physician was to be notified. - Documentation included certified nursing assistant to record the residents' bowel pattern each shift on the bowel movement worksheet; licensed nursing staff would review the bowel movement worksheet at the beginning of each shift, determine the appropriate intervention, record the medication on the Medication Administration Record, and document in the nursing progress note the medication given and the results. Resident #1 had diagnoses including Parkinson's Disease, constipation, irritable bowel syndrome. The 07/28/2025 Minimum Data Set assessment documented the resident's cognition was intact. They required substantial/maximal assistance to dependence on staff for all activities of daily living tasks except for eating when they needed supervision or touching assistance. The 07/22/2025 admission nursing progress note documented the resident's last bowel movement was on 07/21/2025, prior to admission. The 07/22/2025 physician admission orders for bowel medications included:-Docusate sodium (a stool softener used to prevent constipation commonly called Colace) 100 milligram capsule, two capsules orally two times a day, hold for loose stools.-Linzess (for irritable syndrome and chronic constipation) 145 microgram capsule orally once daily. The 07/2025 Medication Administration Record documented Linzess was not administered/not available from 07/22/2025 to 07/25/2025. There was no documented evidence the medical provider was notified the medication was not administered. There was no documented evidence the resident had a bowel movement from 07/22/2025 to 07/26/2025. There was no documented evidence of bowel interventions. The 07/26/2025 at 4:14 PM nursing progress notes by Licensed Practical Nurse #6 documented the resident was on the no bowel movement list. Linzess was delivered and started. The resident had four (4) ounces of prune juice. They were assessed by the registered nurse and the resident stated they wanted to wait to have anything more to promote a bowel movement The 07/26/2025 at 9:47 PM nursing progress notes by Licensed Practical Nurse #6 documented the resident continued with no bowel movement and the registered nurse was aware. A suppository was ordered and given at 2:00 PM with no bowel movement reported. The resident was assessed for bowel sounds by the evening registered nurse. The 07/27/2025 at 10:41 PM nursing progress note by Registered Nurse #10 documented the resident was without documented bowel movement since 07/22/2025 and received a suppository without results. They were assessed for bowel sounds which were hypoactive. Their bowel medications required an evaluation, and they may need an x-ray in the morning. There was no documented evidence the medical provider was notified when Resident #1 was without a bowel movement from 07/22/2025 to 07/27/2025. There was no documented evidence the resident had a bowel movement from 08/05/2025 to 08/09/2025 and no documented evidence of bowel interventions. The 08/09/2025 at 2:04 PM the nursing progress note by Licensed Practical Nurse #6 documented a suppository was given per nursing order with no bowel movement in more than nine (9) shifts and the registered nurse was aware. As of 5:32 PM the resident was pending results from the suppository. There was no documented evidence the resident had a bowel movement from 08/09/2025 to 08/11/2025 and no further documentation related to the resident's bowel medication or results from the 08/09/2025 suppository. There was no documented evidence the medical provider was notified the resident was without a bowel movement for seven (7) days and with no results from the suppository. The 08/11/2025 at 2:57 PM nursing progress note by Unit Manager Registered