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	05/01/2026

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

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services consistent with professional standards of practice, to promote wound healing, prevent infection and prevent new ulcers from developing for one of five residents (Resident #153) reviewed. Specifically, Resident #153 developed a Stage 2 pressure ulcer (partial thickness tissue loss) to the coccyx (tailbone) and there was no documented evidence that wound care orders were clarified to determine if the treatment was daily or every three days; and there was no documented evidence of regular pressure ulcer assessments between [DATE] and [DATE]. Subsequently, the resident's pressure ulcer deteriorated to an unstageable (full thickness tissue loss in which the base of the ulcer is covered with dead tissue) area. This resulted in actual harm to Resident #153 that was not Immediate Jeopardy.Findings include: Resident #153 had diagnoses including stroke, protein-calorie malnutrition, and pressure ulcers. The [DATE] Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, was dependent on staff for all mobility and functional abilities, weighed 80 pounds, was at risk for developing pressure ulcers, did not have any unhealed pressure ulcers, had pressure reducing devices for chair and bed, had nutrition/hydration interventions, and received application of nonsurgical dressings and ointments/medications. The [DATE] at 8:42 AM Registered Nurse #15 progress note documented the resident had a new Stage 2 pressure area on the gluteal cleft (groove between buttocks) measuring 1 centimeter by 0.5 centimeters by 0.2 centimeters. New orders were to cleanse with normal saline, apply Triad paste (a zinc wound paste) and cover with Allevyn (wound dressing). The resident was on comfort measures. The resident's weight fluctuated between 70-80 pounds during the past year. Previous orders were in place to protect the gluteal cleft with Allevyn as the boney prominence of the coccyx protruded and the resident had no fat for protection. The resident had an alternating pressure mattress and specialty cushion in place. The resident's child requested the resident sit up after dinner about 10 days ago and the extra time sitting up could have contributed to the skin on the tailbone breaking down. The resident would be placed back to bed after dinner to support skin integrity. The Comprehensive Care Plan dated [DATE] documented the resident had a pressure ulcer on the tailbone. Interventions included weekly skin evaluations, weekly wound measurements, and referral to the facility's wound care team. The [DATE] at 8:17 AM Nurse Practitioner #11 order documented apply Triad wound dressing paste (zinc paste) topically once daily and as needed. Cleanse gluteal cleft gently and apply Triad paste to open area, cover with Allevyn for protection every three days at 7:00 AM-3:00 PM. The order was entered by Registered Nurse #15. There was no documented evidence that the wound dressing order was clarified with Nurse Practitioner #11 to determine if the frequency of wound care was daily or every three days. The 01/2026 Treatment Administration Record documented apply Triad wound dressing paste topically once daily and as needed; cleanse gluteal cleft gently and apply Triad paste to open area, cover with Allevyn for protection with a start date of [DATE] and scheduled for administration every three days on [DATE], [DATE], [DATE], [DATE], and [DATE] from 7:00 AM-3:00 PM. On [DATE] Licensed Practical Nurse #28 documented the treatment was not completed as the resident was already up in the chair. The [DATE] Nurse (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Practitioner #11 order documented cleanse coccyx wound with normal saline, apply Aquacel Ag foam bandage (an absorbent dressing with silver) and cover with Allevyn (dressing) every other day from 7:00 AM-3:00 PM.There was no documented evidence of wound assessments from [DATE] through [DATE].The [DATE] Nurse Practitioner #11 progress note documented a Stage 3 (full thickness tissue loss) pressure ulcer to the coccyx measuring 1.4 centimeters by 1.0 centimeter by 0.5 centimeters. The plan documented to continue with same wound care treatment and monitoring until healed and continue with nutritional support. The progress note did not include the current treatment in place. The [DATE] Registered Nurse #3 progress note documented a deterioration of the resident's tailbone pressure ulcer, was unstageable, measured 3.0 centimeters by 2.0 centimeters by 0.5 centimeters, and was black with dead tissue.The [DATE] Weekly Skin Condition Monitor completed by Director of Nursing #2 documented a pressure ulcer on the coccyx measured 3.9 centimeters by 3.5 centimeters by 0.3 centimeters with 90% eschar (dry, dead tissue); the wound deteriorated and the treatment plan was changed to cleanse with normal saline, apply skin prep (protectant) to wound edges, apply Medihoney (medical grade honey wound treatment) to wound bed, and cover with Allevyn. Nurse Practitioner #11 orders documented:-[DATE] cleanse wound with normal saline, apply skin prep to wound border skin, apply Medihoney to wound bed, and cover with Allevyn daily from 7:00 AM-3:00 PM. -[DATE] cleanse wound to coccyx with Vashe 0.033% irrigation solution (wound cleanser), everyday and as needed with dressing changes to Stage 2 pressure ulcer on the buttock. The [DATE] at 8:32 PM Registered Nurse #15 progress note documented the coccyx wound measured 6.0 centimeters by 4.5 centimeters by 0.6 centimeters with 100% loose eschar. New orders to apply Santyl (an ointment used to remove dead tissue) daily and cover with Allevyn and change as needed. Requested head-to-toe assessment with wound team as this resident was at high risk for quick changes in skin integrity.The [DATE] Nurse Practitioner #11 progress note documented a [NAME] pressure ulcer (a pressure ulcer that develops rapidly and associated with the dying process) (location not documented) measuring 6.0 centimeters by 4.5 centimeters by 0.6 centimeters with 100% eschar. The wound was worsening.The resident expired on [DATE]. During an interview on [DATE] at 10:50 AM, Registered Nurse #15 stated they found out about Resident #153's pressure ulcer to the tailbone in early [DATE]. They stated the pressure ulcer became worse over the month of February 2026. They stated if a pressure ulcer treatment was ordered every day and was only done every three days, the wound might get worse.During an interview on [DATE] at 12:42PM, Wound Care Nurse #16 stated they assessed Resident #153's pressure ulcer every Tuesday on wound care rounds with the nurse managers and the nurse practitioner. These findings were documented in the electronic health record. Resident #153 was very frail and developed a pressure ulcer on their tailbone that started out as a Stage 2, progressed to a Stage 3, deteriorated to an unstageable ulcer, then advanced to a Kennedy ulcer. They stated they believed the treatment ordered on [DATE] of zinc oxide paste and silicone dressing should have been applied every day rather than every three days. They stated if the treatment was not done daily as ordered, the pressure ulcer may not have healed properly. Wound Care Nurse #16 could not locate Resident #153's wound care records in the electronic health record. Wound Care Nurse #16 stated there was no evidence that wound care assessments were completed between [DATE] and [DATE].During an interview on [DATE] at 1:58 PM, Nurse Practitioner #11 stated they did wound rounds with the wound care nurse. They stated when they ordered treatments daily, they should be provided daily and not every three days. They were not aware the wound treatments were only done every three days, and they were concerned this could have caused the pressure ulcer to increase in size and delayed healing, possibly causing harm to the resident.10 New York Codes, Rules and Regulations 415.12 (c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, and interviews (iQIES Intake 2628724) the facility failed to ensure adequate supervision to prevent accidents for one (1) of seven (7) residents (Resident #151) reviewed. Specifically, Resident #151 required a mechanical lift for transfers and Certified Nurse Aide #37 transferred the resident using a gait belt resulting in a fall. Findings include: Resident #151 had diagnoses including encephalopathy (a brain disorder) and epilepsy (seizure disorder). The 09/11/2025 Minimum Data Set assessment documented the resident had intact cognition and was dependent for transfers. The comprehensive care plan, initiated 09/05/2025, documented the resident was at risk for falls and had a self-care deficit. Interventions included lifted mechanically with two (2) people for transfers. On 09/12/2026 the resident was lowered to the floor by certified nurse aide during an attempt to stand. The 09/05/2025 Registered Nurse Unti Manager #3's Fall Assessment documented Resident #151 was at high risk for falls. The 09/12/2025 Accident and Incident Report completed by Registered Nurse Unit Manager #3 documented at 10:30 AM on 09/12/2025 the resident convinced Certified Nurse Aide #37 they could stand and walk into the bathroom. When Certified Nurse Aide #37 stood the resident after applying a gait belt, the resident's legs gave out resulting in the resident being lowered to the floor. There were no injuries. The care plan was not followed; the resident was care planned for a mechanical lift. The root cause was the aide should not have listened to the resident. The aide was instructed to follow the care plan at all times. During an interview on 04/30/2026 at 1:43 PM, Certified Nurse Aide #37 stated they received education on activities of daily living when they were hired, and they reviewed the residents' care instructions daily. They could not remember all the details of Resident #151's fall but did recall using a gait belt to transfer them and having to lower them to the floor. They were written up but did not recall any related education. During an interview on 05/01/2026 10:35 AM Registered Nurse Unti Manager #3 stated when a resident fell, the nurse who assessed the resident at the time of fall should ensure the care plan interventions were in place and if it was observed that the care plan was not followed there would be a conversation with and education provided to that staff member about following care plans. Resident #151 convinced Certified Nurse Aide #37 they could walk but they required assistance of two (2) and a mechanical lift for transfers. Certified Nurse Aide #37 did not follow the care plan but knew they were supposed to. They stated they provided Certified Nurse Aide #37 with education. 10 New York Codes, Rules and Regulations 415.12(h)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, record review, and interviews (iQIES #2655817) the facility failed to ensure residents were free of any significant medication errors for two (2) of four (4) residents (Residents #109 and #75) reviewed. Specifically, Resident #109 was administered a crushed medication crushed despite instructions that crushing was contraindicated; and Resident #75 was administered all crushed medications together via their gastrostomy tube (enteral tube, a feeding tube directly into the stomach).Findings include:The 09/2024 facility policy Medications Through Eternal Tubes, documented delivering medications correctly to ensure their effectiveness. The policy did not document that medications should be given separately.The 03/2024 facility policy Medication and Treatment Administration documented a physician, nurse practitioner, or physician assistant order must be obtained to crush any medications. Nurses could only crush medications that could be crushed. They may not crush extended release, delayed release, or enteric coated medications.The United States Food and Drug Administration guidelines documented to administer each dose of potassium chloride extended-release tablets without crushing, chewing or sucking the tablets.The 2026 American Society for Parenteral and Enteral Nutrition Clinician's Guide to Medication's via Enteral Feeding Tubes documents do not mix medications together in order to prevent drug-drug interactions which can interfere with the intended therapeutic response or form precipitates that may clog feeding tubes. 1) Resident #109 had diagnoses including low potassium (a mineral required for nerve signals, muscle contractions, and heartbeat) levels. The 02/25/2026 Minimum Data Set assessment (a health status assessment tool) documented the resident was cognitively intact and had a history of low potassium levels.The 04/15/2026 physician order documented potassium chloride extended-release tablet 20 milliequivalents by mouth once daily. Do not crush or chew.The following observation was made during medication administration on 04/29/2026 at 10:01 AM with Licensed Practical Nurse #30. Licensed Practical Nurse #30 handed the surveyor all the medications they were about to administer for verification of the drug, dose, route of administration, and time of administration. This included the potassium chloride extended release 20 milliequivalent tablet. Licensed Practical Nurse #30 crushed the potassium chloride extended-release tablet and mixed it with other crushed medications in apple sauce. They entered Resident #109's room and administered the crushed medications.The April 2026 Medication Administration Record documented on 04/29/2026 at 10:00 AM Licensed Practical Nurse #30 administered 20 milliequivalents of potassium chloride extended-release tablet by mouth.During an interview on 04/30/2026 at 3:10 PM Licensed Practical Nurse #30 stated the electronic medication administration record for Resident #109 documented not to crush the potassium chloride extended-release tablet. They stated they should not crush extended-release tablets, but the facility's pharmacy had approved crushing them if that was the only way the resident would take the medication.2) Resident #75 had diagnoses including right sided paralysis. The 03/26/2026 Minimum Data Set assessment documented the resident's cognition was not assessed, they were dependent on most activities of daily living and had a feeding tube.The comprehensive care plan initiated 01/15/2026 and revised 03/09/2026 documented nutritional risk due to tube feeding. Interventions included medications per physician order.Physician orders documented the following:-50 milliliter water flush before and after medication pass.-hydroxychloroquine (used for autoimmune disease) 200 milligram tablet: give 1.5 tablets by gastrostomy tube once daily.-lisinopril (for blood pressure) 20 milligram tablet: give 1 tablet by gastrostomy tube once daily.-calcium 600 milligrams-vitamin D3 (nutritional supplement) 5 micrograms (200 unit) tablet: give 1 tablet by gastrostomy tube once daily.-metoprolol tartrate (for blood pressure/heart failure) 25 milligram tablet: give 0.5 tablet (12.5 milligrams) by gastrostomy tube twice daily.-aspirin 81 milligram chewable tablet: give 1 tablet by gastrostomy tube once daily.-atorvastatin (lowers cholesterol) 40 milligram tablet: give 1 tablet by gastrostomy tube once daily.-venlafaxine (antidepressant) 37.5 milligram tablet: give 1 tablet by gastrostomy tube twice (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily; -baclofen (muscle relaxant) 10 milligram tablet: take 0.5 tablet by gastrostomy tube 3 times a day.During a medication administration observation on 04/30/2026 at 9:45 AM Licensed Practical Nurse #12 crushed the following medications: venlafaxine, metoprolol tartrate, lisinopril, hydroxychloroquine, calcium plus vitamin D3, baclofen, atorvastatin, and aspirin. At 10:20 AM Licensed Practical Nurse #12 mixed the above medications together with approximately 20 milliliters of water and administered them all at once via the gastrostomy tube followed by approximately 20 milliliters of water. During an interview on 04/30/2026 at 10:51 AM, Licensed Practical Nurse #12 stated they did not know if all the resident's medications could be administered together. They usually only separated liquids and powders from the crushed medications.During an interview on 05/01/2026 at 10:21 AM, Registered Nurse Unit Manager #3 stated when giving medications via a gastrostomy tube the medications could be crushed and administered all together unless the order specified otherwise.During an interview on 05/01/2026 at 11:30 AM, the Director of Nursing stated when giving crushed medications through a gastrostomy tube, all the medications could be given together unless otherwise stated in the order. If a medication order documented do not crush, then it should not be crushed. Instead, an alternative should be found. If a resident preferred to have it crushed, they had that right, but there should be physician notification, a note and maybe an order to cover that.During an interview on 05/01/2026 at 12:24 PM, Pharmacist #31 stated crushed medications were part of their reviews. Resident #109's orders had an entry of crush but neither yes nor no was checked off. If not checked as being a yes for crush, then it would not be in their system, and they would not have noted that in the review. Their potassium could be mixed with water to create a slurry but could not be crushed. They were unsure of the clinical implications if it was administered crushed. There was a liquid alternative to the tablet form. They stated when administering crushed medications through a gastrostomy tube, the medications should be administered one at a time and flushed with water in between to prevent clogging of the tube. That was more of a nursing standard.During an interview on 05/01/2026 at 2:03 PM, Nurse Practitioner #11 stated an order was required to crush a medication. They expected to be notified if staff were crushing medication without an order because some medications could not be crushed or might be incompatible with other medications. They expected potassium not be crushed if there were instructions to not crush as it could cause abnormal heart rhythms and be fatal. They were not aware Resident #109's potassium was being crushed. They should be notified because they would have directed to stop doing so. They stated when administering medications via a gastrostomy tube, they should be given one at a time unless otherwise indicated. Giving all the medications together could reduce their effectiveness. They would want to know if medications were being given all together because they would give directives to not do so. They were not aware Resident #75's medications were being administered together. 10 New York Codes, Rules and Regulations 415.12(m)(2)