

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER The Cottages at Garden Grove, A Skilled Nrsng Comm		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335340 If continuation sheet Page 1 of 26

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) of three (3) residents (Resident #35) and one (1) of 12 Cottages (Cottage 31) reviewed. Specifically, staff in Cottage 31 did not change their gloves or perform hand hygiene in between cleaning resident rooms; and Resident #35's urinary drainage tubing was laying directly on the floor. Findings include: The facility policy Hand Hygiene, revised 08/2024, documented all personnel were required to wash their hands after each direct or indirect resident contact for which hand washing is indicated by accepted professional practice. Additionally, alcohol-based sanitizer could be used on hands that were not visibly soiled after contact with inanimate objects within the vicinity of a resident and after removing gloves. 1) Custodian #25 was observed on 04/28/2026 at the following times wearing the same pair of gloves and not performing hand hygiene: -At 1:52 PM entering room [ROOM NUMBER]. At 1:55 PM they exited the room carrying a bucket and a spray bottle then entered room [ROOM NUMBER]. They did not perform hand hygiene. -At 1:56 PM they exited room [ROOM NUMBER] and retrieved towels from the clean linen closet in the hallway then reentered room [ROOM NUMBER] and went into the bathroom. They did not perform hand hygiene or a glove change. Boxes of gloves were wall mounted and visible from the hall, and no gloves were retrieved by the custodian. -At 1:59 PM they exited room [ROOM NUMBER] with the bucket and spray bottle and entered room [ROOM NUMBER]'s bathroom. They did not perform hand hygiene or a glove change. Boxes of gloves were wall mounted and visible from the hall, and no gloves were retrieved by the custodian. -At 2:03 PM they exited room [ROOM NUMBER], knocked on room [ROOM NUMBER]'s door and entered the room with the bucket and spray bottle. Moments later they exited the room, entered the utility room, and exited seconds later with a bottle of hand wash and reentered room [ROOM NUMBER]. They did not perform hand hygiene or a glove change. -At 2:07 PM they exited room [ROOM NUMBER] and entered room [ROOM NUMBER]'s bathroom carrying the bucket and the spray bottle. Moments later they exited the room, entered the soiled utility room, exited the utility room seconds later and reentered room [ROOM NUMBER]. They did not perform hand hygiene or a glove change. -At 2:12 PM they exited room [ROOM NUMBER], removed their gloves and washed their hands at the sink located off the kitchenette. Custodian #26 was observed on 04/28/2026 at the following times wearing the same pair of gloves and not performing hand hygiene: -At 1:58 PM cleaning the floor in room [ROOM NUMBER]. -At 2:01 PM, placing the mop rag in a bag located just outside the room, picked up the mop, dustpan and set them outside room [ROOM NUMBER], then took a yellow rag from a rolling bucket and began wiping the dresser and the windowsill with it. -At 2:05 PM they exited room [ROOM NUMBER], did not perform hand hygiene or a glove change, knocked on room [ROOM NUMBER]'s door, entered the room with a rag and began to wipe down the bedside table and dresser. -At 2:09 PM they exited room [ROOM NUMBER], moved the mop, broom, rolling bucket, and dustpan outside room [ROOM NUMBER] then entered the room. They did not perform hand hygiene or a glove change. During an interview on 04/28/2026 at 2:16 PM, Custodian #25 stated that day they cleaned the bathrooms and Custodian #26 cleaned the bedrooms and floors. Unless a resident was on specific precautions, they only had to wear gloves to clean rooms. Gloves were worn to protect themselves from germs and to prevent the spread of germs and should be changed in between cleaning rooms. Gloves should be removed prior to leaving a room, not worn outside the room. They usually, upon exiting a room, went right to the main sink by the kitchen to remove their gloves and wash their hands. They stated they did not change their gloves between cleaning all the rooms they just cleaned. They should have but did not because they wanted to make sure everything was clean and was a little too focused on other things. During an interview on 05/01/2026 at 11:35 AM, the Director of Environmental Services (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated gloves should be removed before leaving a room and hands sanitized prior to entering the next room. The same pair of gloves should not be worn to clean multiple rooms. During an interview on 05/01/2026 at 11:43 AM, the Infection Control nurse stated housekeepers should be removing their gloves and performing hand hygiene prior to exiting a room to prevent the spread of infection. 2) Resident #35 had diagnoses including neurogenic bladder (lack of bladder control) and urinary tract infections. The 03/25/2026 Minimum Data Set assessment (a health status assessment tool) documented the resident was cognitively intact, had an indwelling urinary drainage device, and was dependent with activities of daily living. The comprehensive care plan dated 02/25/2026, documented the resident had an indwelling urinary drainage device related to neurogenic bladder. Interventions included monitor for signs and symptoms of urinary tract infection, always keep tubing off the floor, and keep the urine collection bag covered to maintain dignity. The following observations were made of Resident #35: -on 04/27/2026 from 10:15 AM to 11:05 AM sitting in a wheelchair with their uncovered urinary drainage bag under the wheelchair and tubing directly on the floor. At 11:10 AM the resident's foot was on the tubing. -on 04/29/2026 in a wheelchair. The covered urinary drainage bag was under the wheelchair. The tubing contained cloudy urine with sediment and was dragging on the floor. -on 04/29/2026 at 3:03 PM in a wheelchair. The partially covered urinary drainage bag was under the wheelchair, the tubing contained cloudy urine with sediment and was dragging on the floor. -on 04/30/2026 at 10:08 AM in a wheelchair. The fully covered urinary drainage bag was under the wheelchair. The tubing contained cloudy urine with sediment and was dragging on the floor. During an interview on 05/01/2026 at 12:06 PM Certified Nurse Aide #42 stated they could not remember if they had any facility training on managing indwelling urinary drainage devices. They should keep urinary collection bags and the tubing covered. They should notify the licensed practical nurse if there was a problem with the urinary drainage device. During an interview on 05/01/2026 at 12:15 PM Licensed Practical Nurse #43 stated they verified the indwelling urinary drainage devices were clean, there were no kinks in the tubing, urine was flowing freely, and drainage bags were covered. Infection control practices included handwashing, wearing gloves, and proper resident hydration. Urinary drainage tubing should not be on the floor as this could cause urinary tract infections. Licensed Practical Nurse #43 stated keeping the tubing off the floor was part of the resident's care plan and that it was the licensed practical nurse's responsibility to follow the care plan. During an interview on 05/01/2026 at 11:43 AM, the Infection Control nurse stated urinary drainage device tubing should not be on the floor because the floor was dirty, and contamination could occur. 10 New York Codes, Rules and Regulations 415.19(a)(b)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews, the facility failed to ensure residents were treated with respect and dignity in a manner and in an environment that promoted maintenance or enhancement of quality of life for one (1) of one (1) resident (Resident #129) reviewed. Specifically, Resident #129's urinary catheter drainage bag (collects urine) was uncovered and visible to other residents, visitors, and staff. Findings include: The facility policy Notification of Rights, revised 05/23/2025, documented the facility would provide an environment where all residents would maintain dignity and quality of life while receiving care. Resident #129 had diagnoses including neurogenic bladder (lack of bladder control). The 04/12/2026 Minimum Data Set (a resident assessment tool) documented the resident had intact cognition, required partial/moderate assistance with toileting hygiene and showering/bathing, required substantial/maximal assistance with personal hygiene, and had an indwelling urinary catheter. The 01/21/2026 Comprehensive Care Plan documented the resident had an alteration in elimination related to the use of an indwelling catheter. Interventions included keeping the urinary drainage bag covered to maintain dignity and utilizing a leg drainage bag as appropriate. Resident #129 was observed at the following times: -on 04/27/2026 at 11:20 AM, sitting in their wheelchair near the doorway of their room with their urinary drainage bag clipped to the bottom of the wheelchair. The drainage bag was uncovered, 1/4 full of amber colored urine, and was visible to staff, visitors and other residents in the area. The resident stated the drainage bag was never kept covered but if it was an option they would like. -on 04/28/2026 at 12:44 PM, sitting in their wheelchair at the dining room table with their urinary drainage bag clipped to the bottom of the wheelchair. The drainage bag was uncovered, contained amber colored urine, and was visible to staff, visitors and other residents in the cottage. -on 04/28/2026 at 1:40 PM, sitting in their wheelchair in the common area with their urinary drainage clipped to the bottom of their wheelchair. The drainage bag was uncovered, the tubing was resting directly on the floor, and was visible to staff, visitors and other residents in the area. -on 04/29/2026 at 12:19 PM, sitting in their wheelchair at the dining room table with their urinary drainage bag clipped to the bottom of the wheelchair. The drainage bag was uncovered, contained amber colored urine, and was visible to staff, visitors and other residents in the area. -on 04/30/2026 at 10:45 AM, sitting in their wheelchair in the common area with their urinary drainage bag clipped to the bottom of the wheelchair. The drainage bag was uncovered, 1/2 full of amber colored urine, and was visible to staff, visitors and other residents in the area. During an interview on 04/30/2026 at 1:28 PM, Certified Nurse Aide #22 stated they were unsure if the facility had privacy covers for urinary drainage bags. Resident #129's urinary drainage bag was never covered, and it was a dignity issue. During an interview on 04/30/2026 at 1:38 PM, Licensed Practical Nurse #23 stated they noticed Resident #129's urinary drainage bag was not covered. They should have spoken to the certified nurse aides about it or covered it themselves. They were unsure if there were extra privacy bags in the cottage, but they were going to find one because it was a dignity issue and it should have been covered. During an interview on 05/01/2026 at 12:06 PM, Registered Nurse Manager #24 stated certified nurse aides were responsible for completing catheter care and ensuring urinary drainage bags had a privacy cover on them if the resident was not using a leg bag (a collection bag attached to the resident's leg and under clothing). Every cottage had privacy bags available and if they ran out staff should ask for more. It was not dignified for Resident #129's to be uncovered. 10 New York Codes, Rules and Regulations 415.5 (a)		

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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. Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for two (2) of two (2) residents (Residents #18 and #131) reviewed. Specifically, Resident #18 did not receive their prescribed furosemide (diuretic medication) for 4 days, was not weighed daily as ordered, and there was no documented evidence the medical provider was notified; and Resident # 131 had an unwitnessed fall, and neurological checks were not completed as ordered. Findings include: The facility policy Medication Administration, last revised/ reviewed 09/17/2025, documented if a medication has not been delivered by pharmacy and/or is not available, the licensed practical nurse would check to see if the medication was in the automated dispensing system. If the medication is not in the automated dispensing system, the licensed practical nurse would report this to the supervisor/nurse manager and document in the electronic medical record. The supervisor/nurse manager will notify medical for further instruction and document response/intervention/substitution in the electronic medical record. The facility policy Monitoring Weights, revised 05/2022, documented if the resident had a 5 pound weight change the Registered Nurse Manager would requests any reweights to be obtained during morning huddle. The facility policy Neurological Evaluation Neuro Checks, last reviewed 06/07/2023, documented neurological evaluations will be initiated after an unwitnessed fall. Neuro checks will be done every 4 hours for the first 16 hours then every 8 hours for 48 hours. 1)Resident #18 had diagnoses including congestive heart failure (the heart does not pump well and can cause fluid buildup), chronic obstructive pulmonary disease (lung disease), and peripheral vascular disease (reduced blood flow to the limbs). The 01/18/2026 Minimum Data Set (a resident assessment tool) documented the resident had intact cognition, did not reject care, was dependent with transfers, weighed 112 pounds, had no weight changes at 1 or 6 months, and did not take a diuretic. WeightsPhysician orders documented:-01/12/2025 daily weights: notify medical with a weight gain of 2 pounds a day/ 5 pounds in a week. Licensed practical nurse to document weight daily on flow sheet on day shift 7:00 AM - 3:00 PM.-02/06/2026 furosemide 40 milligrams once daily for congestive heart failure. The 01/12/2026 revised comprehensive care plan documented the resident had congestive heart failure. Interventions included medications administered as prescribed by the physician, monitor weights as ordered, and notify physician of weight changes of 1-2 pounds in a day. The January 2026 Medication Administration Record documented daily weights, notify medical with a weight gain of 2 pounds a day or 5 pounds a week. Licensed practical nurse to document weight on daily weight flow sheet with a start date of 01/12/2026 at 5:28 PM. There was no documented evidence daily weights were obtained on 01/16/2026, 01/19/2026, 01/20/2026, and 01/25/2026. The February 2026 Medication Administration Record documented daily weights, notify medical with a weight gain of 2 pounds a day or 5 pounds a week. Licensed practical nurse to document weight on daily weight flow sheet with a start date of 01/12/2026 at 5:28 PM. There was no documented evidence daily weights were obtained on 02/04/2026, 02/14/2026, 02/15/2026, 02/17/2026, 02/18/2026, 02/21/2026, 02/22/2026, 02/23/2026, 02/24/2026, 02/27/2026, and 02/28/2026. The resident refused daily weights on 02/05/2026, 02/06/2026, and 02/20/2026. No weights were documented on 02/12/2026 no scale; and 02/13/2026 scale broken. The March 2026 Medication Administration Record documented daily weights, notify medical with a weight gain of 2 pounds a day or 5 pounds a week. Licensed practical nurse to document weight on daily weight flow sheet with a start date of 01/12/2026 at 5:28 PM. There was no documented evidence daily weights were obtained on 03/01/2026, 03/02/2026, 03/09/2026, 03/10/2026, 03/11/2026, 03/12/2026, 03/13/2026, 03/14/2026, 03/15/2026, 03/18/2026, 03/19/2026, 03/24/2026, 03/27/2026, and 03/28/2026. The resident refused daily weights on 03/03/2026, 03/06/2026, 03/16/2026, and 03/23/2026. No weight was documented on 03/29/2026 office visit and hospitalization. The April 2026 Medication Administration Record documented daily weights, notify medical with a weight gain of 2 pounds a day (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or 5 pounds a week. Licensed practical nurse to document weight on daily weight flow sheet with a start date of 01/12/2026 at 5:28 PM. There was no documented evidence of daily weights were obtained on 04/07/2026, 04/08/2026, 04/12/2026, 04/16/2026, 04/20/2026, 04/21/2026, 04/25/2026, 04/26/2026, and 04/28/2026. The April 20206 Medication Administration Record on 04/17/2026 Licensed Practical Nurse #21 documented the resident weighed 99.6 pounds. On 04/18/2026 Licensed Practical Nurse #9 documented the resident weighed 102.5 pounds (2.9-pound weight gain in 1 day). There was no documented evidence a medical provider was notified the resident had a weight gain of 2 pounds or more in 1 day. Furosemide On 03/29/2026 at 12:17 PM, Registered Nurse Supervisor #7 documented they were notified the resident was restless. Upon assessment, the resident was found lying in bed in respiratory distress. The resident was noted to be bradycardic (abnormally slow heart rate) with a heart rate of 30 beats per minute. Their blood pressure was 160/80 millimeters of mercury (high), temperature of 98.2 degrees Fahrenheit (normal), oxygen saturation 92% on 4 liters of oxygen via nasal cannula, and respiratory rate of 28 breaths per minute (high). Medical was notified and an order was received to transfer the resident to the hospital for further evaluation and management. The resident was transferred to the hospital at 11:00 AM. The 04/02/2026 Hospital Discharge Summary documented the resident was treated for acute respiratory failure secondary to chronic obstructive pulmonary disease with possible concurrent pneumonia. Medications on discharge included 40 milligrams of furosemide daily in the morning. The 04/02/2026 at 3:03 PM, Registered Nurse Manager #8 progress note documented the resident returned to the facility from the hospital and home medications would be continued. The 04/03/2026 Nurse Practitioner #11 progress note documented the resident was seen at the request of nursing due to chronic pulmonary disease exacerbation. The resident was sent to the emergency room after being in respiratory distress and was readmitted to the facility. Their plan included continue furosemide for congestive heart failure. The 04/06/2026 Nurse Practitioner #1 order documented furosemide 40 milligram tablet once daily for congestive heart failure. The April 2026 Medication Administration record documented furosemide 40 milligrams once daily at 8:00 AM. On 04/03/2026, Licensed Practical Nurse #9 documented the medication was not provided due to not being in the medication cart; on 04/04/2026, Licensed Practical Nurse #9 documented the medication was not in from the pharmacy; on 04/05/2026, Licensed Practical Nurse #9 documented the medication was not available; and on 04/06/2026 Licensed Practical Nurse #9 documented the medication was not in from the pharmacy. The facility's Automatic Medication Dispensing System active inventory list documented furosemide 40 milligram tablets was included in the inventory. On 04/06/2026 at 10:35 AM, Registered Nurse Manager #8 documented they followed up with the pharmacy and the resident's furosemide medication would be delivered that day. There was no documented evidence the resident was assessed following four (4) missed doses of furosemide; if the medication omission was reported to the medical provider; or if the medication was available in the automated dispensing system. The facility's 04/27/2026 in progress investigation documented Licensed Practical Nurse #9 had a major medication error. Licensed Practical Nurse #9's written statement documented on 04/03/2026 - 04/06/2026 the resident's furosemide medication was not administered because it was not in the medication cart, and they did not retrieve the medication from the automatic medication dispensing system. They ordered the medication from the pharmacy. The investigation documented Licensed Practical Nurse #9 was educated on what to do if a medication was not available. During an interview on 04/29/2026 at 3:01 PM Certified Nurse Aide #13 stated the nurse would tell the certified nurse aides who needed to be weighed. The certified nurse aides obtained the resident's weight and told the nurse. If the resident refused to be weighed, they would reapproach the resident and tell the nurse. If the resident refused to be weighed the nurse should document the refusal in the chart. Resident #18's weight was supposed to be obtained daily, and the resident did refuse to be weigh a lot. They told the nurse when the resident refused. During an interview on 05/01/2026 at 10:19 AM, Licensed Practical Nurse #12 stated weights were listed in the computer when they were to be obtained. If a resident (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused to be weighed, they would reapproach them and if they continued to refuse, they would document the refusal in the chart. Resident #18 was on daily weights and if there was a 2 pound weight change from the previous day the medical provider should be notified. The resident was on daily weights due to their medical condition of congestive heart failure. The resident did not refuse to be weighed when they worked with them. If they had a weight gain greater than 2 pounds in one day or 5 pounds in a week the nurse should tell the supervisor who notified medical of the weight gain. During an interview on 05/01/2026 at 11:02 AM, Registered Dietitian #14 stated daily weights were monitored by the Registered Nurse Manager or Nursing Supervisor and the Registered Nurse Manger or Nursing Supervisor notified medical of any changes per the order. Resident #18 sometimes refused weights. They were ordered for daily weights related to their diagnosis of congestive heart failure. They did not review the residents' weights daily to see if they were obtained but reviewed them weekly to monitor weight trends. The interdisciplinary team reviewed weights weekly during the weight meeting. During an interview on 05/01/2026 at 11:21 AM, Registered Nurse Unit Manager #8 stated they were unaware the resident was not being weighed daily as ordered and medical was not notified when the resident had greater than a 2 pound weight gain in 1 day. They stated if the resident did have a weight gain greater than 2 pounds in 1 day or 5 pounds in a week, staff should obtain a reweight to confirm the weight was accurate and then notify the registered nurse or Nursing Supervisor who would notify medical. The resident missed 4 days of furosemide because the nurse did not retrieve the medication from the automatic dispensing system when the resident was readmitted from the hospital and did not tell anyone the medication was unavailable. Once the facility was made aware of the incident during a family meeting an investigation was started. The nurse was written up for the medication error. During an interview on 05/01/2026 at 1:30 PM the Director of Nursing stated when a resident was readmitted to the facility the admitting nurse reviewed the discharge summary from the hospital to ensure all medications and treatments were current. If the resident had a medication ordered that was not in the medication cart the facility had an automatic medication dispensing system the nurse could retrieve medication from. All the nurses had access to the automatic medication dispensing system. They should also tell the nurse supervisor the medication was not in the cart, and it needed to be removed from the automatic medication dispensing system. The facility was alerted Resident #18 did not receive their ordered 40 milligrams furosemide for 4 day during a family meeting last week. Once they were aware of the situation an investigation was started. Licensed Practical Nurse #9 received a written warning and education on what to do when medications were not available. Resident #18 had a diagnosis of congestive heart failure and should have received the medication as ordered. This was considered a major medication error. During an interview on 05/01/2026 at 1:58 PM, Nurse Practitioner #11 stated Resident #18 had an order for daily weights related to a diagnosis of congestive heart failure. If they had a weight gain greater 2 pounds in 1 day or 5 pounds in a week, they should be made aware so they could evaluate the resident. The nurse managers or nursing supervisors were responsible for notifying the medical team of any significant weight changes. They were notified following a family meeting last week, the resident missed several doses of furosemide. They expected the nursing staff to notify them if any medications were not provided. The resident had a history of congestive heart failure, and their weights should be monitored and medication provided to prevent possible fluid overload. Interviews were attempted with Licensed Practical Nurses #9 and #10 return telephone calls were not received prior to survey exit. 2) Resident #131 had diagnoses including left sided paralysis. The 03/12/2026 Minimum Data Set assessment documented the resident had moderately impaired cognition, had no falls, and was dependent for most activities of daily living. The comprehensive care plan, initiated 12/18/2025, documented the resident was at risk for falls. Interventions included investigate and meet needs regarding frequent falls. The 04/13/2026 Accident and Incident Report documented at 8:38 AM on 04/13/2026 the resident had an unobserved fall in their room resulting in bruising to their forehead and a skin tear to their left elbow; neurological checks were initiated. The 04/13/2026 at (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:29 AM physician order documented a neurological evaluation template in a progress note would be completed every 4 hours for 16 hours then every 8 hours for 48 hours. The April 2026 Treatment Administration Record documented the resident was scheduled to have neurological checks on:-04/13/2026 at 10:30 AM, 2:30 PM, 6:30 PM, and 10:30PM-04/14/2026 at 10:30 AM and 6:30 PM-04/15/2026 at 2:30AM, 10:30 AM and 6:30PM Nursing progress notes did not document neurological checks were completed as scheduled on:-04/13/2026 at 6:30 PM or 10:30 PM-04/14/2026 at 10:30 AM or 6:30PM-04/15/2026 at 6:30PM During an interview on 05/01/2026 at 10:02 AM, Licensed Practical Nurse #43 stated neurological checks were done for unwitnessed falls. A check was done at the time of the fall and was documented in the computer. The registered nurse entered the order for the neurological checks. When due, it would come up on the treatment administration record for the nurses to complete. The nurse then completed the prepopulated form and initialed the administration record as complete. If they were unable to complete their documentation, they should let the supervisor know. During an interview on 05/01/2026 at 11:43 AM, Registered Nurse Unit Manager #8 stated when a resident fell a registered nurse did an assessment which included a neurological check. They entered the order for further neurological checks, and the times were auto populated. Resident #131had an unwitnessed fall that resulted in significant bruising. They were not aware Resident #131 did not have all their neurological checks completed. If a nurse was unable to complete the neurological checks, they should report it to the supervisor. 10 New York Code Rules and Regulation 415.12 (k) (1)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observations, interviews, and record review the facility did not ensure a resident with limited range of motion received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility was demonstrably unavoidable for one (1) of two (2) residents (Resident #66) reviewed. Specifically, Resident #66 had an order for a thoracolumbar sacral orthosis (a back brace used to keep the spine extended after a fracture) and was observed without the brace and there was no documented evidence the provider was notified of resident refusals. Findings include: The 03/2028 facility policy Devices and Equipment, documented residents with limited mobility would receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility was unavoidable. Resident #66 had diagnoses including compression fracture in their back. The 04/03/2026 Minimum Data Set assessment documented the resident had severely impaired cognition, no rejections of care, required moderate assistance with most activities of daily living and received occupational and physical therapy. The 04/01/2026 physician order documented thoracolumbar sacral orthosis brace when out of bed or sitting upright; could remove when lying down or sleeping. There was no documented evidence the comprehensive care plan included the spine fracture or use of the back brace. The 4/15/2026 Occupational Therapist #4's Treatment Encounter note documented a discharge summary was initiated and the resident was wearing and compliant with the back brace. During the following observations Resident #66 was not wearing the back brace: -on 04/27/2026 at 11:27 AM while sitting upright in their wheelchair. The back brace was sitting on the floor in their room. -on 04/29/2026 at 9:45 AM while sitting upright in their wheelchair. The back brace was sitting on the bedside table in the resident's room. -on 04/30/2026 at 11:47 AM while sitting upright in their wheelchair. The back brace was draped over the back of a chair in their room. The April 2026 Treatment Administration Record documented thoracolumbar sacral orthosis brace when upright and out of bed with a start date of 04/03/2026. During the 7:00 AM-3:00 PM shift the brace was not administered due to resident refusal on: 04/04/2026, 04/07/2026, 04/09/2026, 04/11/2026 -04/13/2026, 04/18/2026, 04/19/2026, and 04/21/2026 - 04/30/2026 (on 04/27/2026 by Licensed Practical Nurse #6, and 04/29/2026 and 04/30/2026 by Licensed Practical Nurse #12). There was no documented evidence the provider or therapy was notified the resident refused to wear the back brace. During an interview on 05/01/2026 at 8:47 AM, Certified Nurse Aide #5 stated braces and splints were on the care instructions and if a resident refused, they were supposed to report it to the nurse. Resident #66 had a back brace. The resident did not like the brace. They took care of the resident on 04/30/2026 during the day shift and the resident refused to put the brace on. They did not report the refusals but should have. They stated they likely got caught up in something and forgot to do so. During an interview on 05/01/2026 at 9:16 AM, Occupational Therapist #4 stated if a resident was not compliant with a device they should provide education, explore why the resident was refusing and possibly implement other devices the resident might comply with. Resident #66 was supposed to wear a back brace when out of bed due to a spine fracture. The brace was to promote healing and prevent twisting or bending of the spine. When discharged from therapy on 04/15/2026, the resident was compliant with the brace, and it was not reported to them the resident was refusing it. They would like to be notified because they could have gotten involved and maybe the resident would have responded better to someone else. During an interview on 05/01/2026 at 9:44 AM, Licensed Practical Nurse #6 stated usually the certified nurse aides applied the splints/braces, and the nurses documented it. Resident #66 refused the brace most of the time because they complained about related pain. They reported the refusals to whichever registered nurse was covering that cottage and was unsure what happened after that. During an interview on 05/01/2026 10:10 AM, Registered Nurse Manager #3 stated if a resident refused their brace or splint it was documented in a (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note and the provider and therapy should be notified. They were not aware Resident #66 refused their back brace and was unsure if the other managers who helped cover that cottage were aware. They did not see any progress notes related to the physician or therapy being notified of the refusals. 10 New York Codes, Rules and Regulations 415.12(e)(2)		

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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 Unit 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 Unit 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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain and or maintain their highest practicable physical, mental, and psychosocial well-being for one (1) of three (3) residents (Residents #134) reviewed. Specifically, Residents #134 had behavioral symptoms related to dementia and did not have a person-centered care plan that included and supported their dementia care needs. Findings include: The facility policy Behavior Management Policy, last reviewed 9/2025, documented the nursing staff would conduct an assessment when a behavior occurs. Contributing factors such as pain, infection, environment, and emotional needs must be evaluated. The interdisciplinary team reviewed behavioral incidents and patterns. Interventions included preventative measures, communication, de-escalation, and maintaining safety. Psychotropic medications were only to be used when clinically necessary and ordered by a licensed prescriber. Non-pharmacological strategies must be attempted and documented first. Ongoing monitoring for effectiveness and adverse effects was required. All behavioral episodes, interventions, and outcomes must be documented in the medical record and updates to care plans will be recorded. The facility policy Behavioral Interventions, last reviewed 05/23/2025, documented the social worker will document on the behavior care plan, the interventions being utilized, and explore alternatives to medications with the interdisciplinary team. If a resident had increased behavioral issues requiring as needed or increased use of psychotropic medication the social worker would provide increased psychosocial support to the resident, work with the interdisciplinary team to develop non-pharmacological interventions and document the effectiveness of the interventions in a weekly progress note. The facility policy Dementia Care, last reviewed 03/2025, documented the facility would involve the resident or family/representative in discussions about the potential use of any specific approaches to their care. The resident's care should be tailored to personal care approaches, meal service, and activities to the individual by paying close attention to past life history, as well as current functional and cognitive levels. Staff were to respond to any behavior of distress/emotional as an unmet need versus attention to prevent an increase in agitation or behaviors. Resident #134 had diagnoses including dementia with psychotic disturbance, Parkinson's disease (a progressive neurological disease), and anxiety. The 4/17/2026 Minimum Data Set documented had severely impaired daily decision making skills, fluctuating inattention, wandered 1-3 of 7 days, required supervision for mobility, and utilized antipsychotic medication on a routine basis. The comprehensive care plan documented:-02/12/2025 cognitive deficits and short-term memory loss related to dementia and Parkinson's disease. Interventions included orienting the resident frequently to their surroundings and daily routine, maintaining a quiet environment, approaching in a calm slow manner, engaging in appropriate social conversations, providing reminders, cues and regular supervision, allowing time to respond, reducing decision making that caused stress, and encouraging participation in self-care. 02/13/2025 behavioral symptoms including exhibiting physically aggressive behaviors towards staff and others. Interventions included to identify a behavior pattern, remove resident from the situation triggering their behavior, evaluate their comfort level and medicate as necessary, administer medications as ordered, refer to a psychiatrist, orient to their daily routine, redirect negative behaviors, encourage participation in their activities of daily living, social services evaluation and follow up, record all behavior episodes, notify the medical provider of behavioral changes, allow time to de-escalate if agitated, offer one-to-one interaction for comfort, and offer their favorite snacks. -03/11/2025 was at risk for wandering and elopement due to impaired cognition with poor decision-making skills and ability to ambulate self with aimless wandering and exit seeking behaviors. Interventions included providing increased supervision during periods of increased wandering or (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agitation, providing and encouraging activities for diversion, notifying the supervisor if increased wandering was noted, and approaching in a calm manner. The undated care instructions documented the resident had behaviors and to provide one-to-one interaction for reassurance and comfort, offer snacks while giving choices, and encourage to watch movies. The resident also loved popcorn. The resident was on a puree diet with nectar thick liquids. The 03/19/2025 physician order documented to inject 2 milliliters (12.5 milligrams) of Risperdal (antipsychotic) extended release every 2 weeks on Wednesday with an end date of 04/28/2026. The 04/28/2026 physician order documented to inject 2 milliliters (25 milligrams) of Risperdal extended release by intramuscular route every 2 weeks on Wednesday. The 02/17/2026 Psychiatric Periodic Evaluation by Nurse Practitioner #40 documented the resident was seen for a follow-up psychiatric evaluation and medication review following prior medication change. The resident was noted to be sitting in the common area in a chair, awake, and alert to person, with baseline confusion. Per the nursing staff, there were no acute behavioral disturbances following Buspar (an anti-anxiety medication) gradual dose reduction in January 2026 from 20 milligrams twice a day to 15 milligrams twice a day. The resident was eating and sleeping fairly well. The resident could be socially inappropriate and sometimes tried to eat food from other residents' plates but was able to be redirected. The recommendation was to continue to monitor the resident's behavior, prioritize nonpharmacological interventions, continue to establish a routine, ensure all needs were met, evaluate for discomfort, and continue to reorient to surroundings. The 04/17/2026 Psychiatric Periodic Evaluation by Nurse Practitioner #41 documented the resident was observed to be comfortably sitting in the common area. They remained nonverbal for the encounter. Their affect appeared surprised and fixed without restlessness or agitation. They did not appear to be internally preoccupied or responding to internal stimuli. Per the chart review, they displayed behaviors including wandering around the cottage, pushing occupied wheelchairs without the consent of other residents, and trying to exit the side door. They had not been physically aggressive and there were no other identified concerns. There was no gradual dose reduction recommended at the time with a recommendation to utilize the antipsychotic medication with caution due to sudden cardiac death risk. It was recommended to prioritize nonpharmacological interventions and to have follow ups on a routine basis. The certified nurse aide behavior documentation documented:-the day shift (7:00 AM to 3:00 PM) on 04/23/2026 the resident was wandering, and their behavior was not easily altered.-the evening shift (3:00 PM to 11:00 PM) on 04/23/2026 the resident had insomnia, had wandering that was not easily altered, had socially inappropriate/disruptive behavior of being threatening that was not easily altered, and was resistive to care but was easily altered.-the evening shift on 04/24/2026 the resident had repetitive physical movements, wandering, verbally abusive behavior, physically abusive behavior, socially inappropriate behavior, and was resistive to care. All the resident's behaviors were easily altered.-the day shift on 04/25/2026 the resident was wandering and was resistive to care; both were easily altered. -the day shift on 04/26/2026 the resident was wandering which was not easily altered.-the day shift on 04/28/2026 the resident was wandering which was not easily altered.-the evening shift of 04/28/2026 the resident was wandering which was not easily altered and had socially inappropriate/disruptive behavior which was not easily altered. Nursing behavior notes documented the following:-on 04/24/26 at 9:36 PM by Licensed Practical Nurse #38 the resident wandered and was socially inappropriate. The resident continued to randomly enter rooms and disturb other residents. They checked off on the pre-populated list they provided a calm structured environment, checked the resident for unmet needs, provided direction in positive manner, initiated a psychiatric consult and gave psychiatric medications as ordered. The behavior was still present.-on 04/27/2026 at 2:24 PM by Licensed Practical Nurse #12 the resident always wandered and was easily redirected.-on 04/27/2026 at 9:41 PM by Licensed Practical Nurse #38 the resident was wandering and was socially inappropriate. They checked off on the pre-populated list that they provided a calm structured environment, checked the resident for unmet needs, redirected the resident and engaged them in diversional activities, and provided direction in a positive manner. The (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavior was still present.-on 04/28/2026 at 10:11 PM by Licensed Practical Nurse #38 the resident continued to enter random rooms without an invitation and was annoying to other residents. They checked off on the pre-populated list that they provided a calm structured environment, checked the resident for unmet needs, redirected the resident and engaged them in diversional activities, and provided direction in a positive manner. The behavior was still present. The 04/09/2026 Registered Nurse Manager #20 progress note documented the certified nurse aides and other residents were noticing the resident had increased wandering episodes into other resident rooms and was displaying inappropriate behaviors. The resident was going into other resident rooms and pulling down their pants. The resident also went into another resident's room and laid down in bed with the other resident. Redirection was provided. The stop signs located on the doorways were not working to stop the resident from wandering into other residents' rooms. The resident's Buspar was decreased. The medical provider was notified of recent behaviors and advised changing the Buspar dose back to the original dose. The order was placed. Staff were to continue to monitor behaviors. The 04/22/26 at 2:51 PM Registered Nurse Manager #20 progress note documented the certified nurse aides notified them the resident was having increased behavioral episodes including climbing into other resident beds, wandering into other resident rooms to use their bathroom and stripping down. The behavior was going on for a couple of weeks. The resident was frequently going into other resident rooms and using their bathrooms. Medical was made aware and orders for a urinary analysis to rule out urinary tract infection was ordered. Staff were unable to get a sample, so a straight catheter was ordered to obtain the sample. The 04/28/26 at 11:40 AM Registered Nurse Manager #39 progress note documented the resident had increased behaviors of wandering into other resident rooms. The resident's urinalysis came back negative for a urinary tract infection. The medical provider was made aware and advised increasing the resident's dose of Risperdal to 25 milligrams. The order was transcribed and initiated. The 04/28/2026 Physician #48 progress note documented Resident #134's behaviors were progressively getting worse over the last week or two. The resident was wandering into other resident rooms and was more agitated. The plan was to discuss with the resident's family about considering increasing the resident's Risperdal to 25 milligrams daily. There were no documented social services progress notes regarding the resident's behaviors, increased wandering, or increases in psychotropic medication. The following observations of Resident #134 were made:-on 04/28/2026 at 12:15 PM moving with a shuffled quick gait to the recliner chair in front of the television after lunch was cleared. At 12:16 PM they moved to a different chair in the common area, then down the hall to a different chair, then into their room, then out into a chair in the hallway next to their room. At 12:17 PM they moved back to the chair in the lounge area, then to a different chair in the area and then back to the original chair. At 12:22 PM, they moved back to the dining room table. At 12:31 PM, Certified Nurse Aide #44 stated there they go as the resident went to a stationary chair in the lounge area then went to a stationary chair in the hallway. At 12:33 PM the resident went back to the stationary chair in the lounge area with their feet up on an ottoman. At 2:57 PM, they were brought into the lounge area by Certified Nurse Aide #45 and the resident got up from the chair and went back to the hallway chair. At 2:58 PM, Certified Nurse Aide #45 brought them back out to the lounge area and got bingo supplies. At 3:03 PM, the resident was holding up the bingo numbers for the other residents playing at the table. Certified Nurse Aide #44 stated it was the first time they had seen the resident hold the cards for bingo, but the resident had gone to the cabinet that morning and had gotten them out on their own. -on 04/29/2026 at 3:29 PM in the darkened hallway in a chair outside their room looking around. At 3:35 PM, the resident came out to the lounge area. Certified Nurse Aide #46 asked what the resident was doing as they went from one seat to another. They took the resident's hand and led them back down the hallway. At 3:36 PM Certified Nurse Aide #47 walked the resident back to the lounge area. At 3:39 PM the resident left the common area and went back down the hallway toward their room. At 3:40 PM, they came back to the lounge area, sat in a chair then got up quickly and went back down the hallway. At 3:44 PM Certified Nurse Aide #46 stood across from (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	where the resident was seated on a chair in the darkened hallway and informed the resident where their room was then walked away. At 3:46 PM the resident opened the door to resident room [ROOM NUMBER] then closed it and went into resident room [ROOM NUMBER]. The female resident in room [ROOM NUMBER] told the resident to leave and the resident left the room and sat back in the chair down the hallway. At 3:47 PM, the resident went and sat in the common area. Certified Nurse Aide #46 asked the activity personnel in the lounge area where the resident was. Upon seeing the resident, they stated they did not want the resident going into other resident rooms. At 3:49 PM, the resident went into resident room [ROOM NUMBER] and then exited, shutting the door upon exit while Certified Nurse Aide #46 was charting in the lounge area. -on 04/30/2026 at 10:25 AM they went into resident room [ROOM NUMBER] towards the bathroom and then walked out. They went into resident room [ROOM NUMBER], had a hand on the other resident's walker and was told by the female resident they could not be in there. The resident calmly left and went back to resident room [ROOM NUMBER]. They were stopped by Certified Nurse Aide #45 who guided the resident to the lounge area and got the resident some juice as the resident sat in the recliner. At 10:40 AM the resident was calmly sitting in the lounge area drinking from their cup. During an interview on 04/30/2026 at 1:39 PM, Certified Nurse Aide #45 stated they received dementia care training once a year on an online platform. They knew what interventions to utilize for a resident with behaviors by contacting the nurse manager to ask what to do. Resident #134 had wandering behaviors which were sometimes redirected by getting the resident to sit down with something else like bingo. The resident's behaviors had remained consistent and had not increased lately to their knowledge. Usually after lunch was when the resident's behaviors were worse. It was hard to determine what the resident liked to do because they did not talk. The resident seemed to enjoy bingo though. During an interview on 04/30/2026 at 4:05 PM Certified Nurse Aide #47 stated they received dementia care training at the end of the year on an online platform. The interventions to use when a resident had behaviors were to reapproach and redirect. They tried to do things like an activity, offer food or drinks and move them away from other residents. Resident #134 had behaviors of wandering. It was non-stop with the resident going in and out of other resident rooms. They tried to redirect the resident to keep them out of other resident rooms and their personal space. Occasionally they turned on the resident's television and asked them to lie down and that worked. They also offered the resident a drink or snack at night and put on a movie. The resident had increased wandering for the last 3 weeks, particularly after dinner. The resident liked bingo and sometimes magazines. During a phone interview on 05/01/2026 at 10:48 AM Licensed Practical Nurse #38 stated they did not recall having dementia care training at that facility. They did not know if behavioral interventions were on the care plan as they had not looked. Resident #134 had behaviors of wandering into other resident rooms and through any open or accessible closed door. They also got into other residents' beds and pulled their clothes off while in other residents' rooms. The resident had not been aggressive or had any violent behavior. The resident had been on 12.5 milligrams of Risperdal, but it was increased to 25 milligrams because the resident was wandering into other resident rooms. The resident had increased behaviors which was why they did a urinary analysis on them, but it came back negative. They often sat the resident down and gave them pudding or ice cream; they liked to eat. Turning on the television to a channel the resident liked also helped; they liked sports. The resident just needed to be kept busy as they did not sit still for long. They were unaware of any new interventions put in place besides the medication increases with the resident's increased wandering. During an interview on 05/01/2026 at 11:09 AM Registered Nurse Manager #20 stated dementia care training was done yearly through online academy training. Interventions for resident behaviors were on the care plan. They, as the nurse manager, completed the care plans. Care plans should be personalized, and diversional activities should be specified for what worked for each resident. Resident #134 had behaviors including wandering into other resident rooms, but they were very easily redirected. Recently the resident had stripped down in other resident rooms. The resident had no episodes of aggression toward themselves or others. Due to the increase in (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wandering and new behavior of stripping down in other resident rooms, they got a urine sample on the resident. When it was negative for infection, they adjusted some of the resident's psychotropic medications. The resident liked to go on walks, participated in activities for a limited period but liked to sit and watch them, and they gave the resident a pudding or a drink. The resident's Risperdal was increased due to the increased wandering behavior and the stripping down in other resident rooms. During a phone interview on 05/01/2026 at 11:35 AM Physician #48 stated they recently increased Resident #134's Risperdal due to an increase in behaviors. The resident was going into other resident rooms at night and there were other things that occurred. Wandering was not an indication for Risperdal, but they had some behaviors prior to starting Risperdal, so they were trying an increase in dose. They expected the staff to utilize nonpharmacological interventions prior to medication adjustments. The nonpharmacological care plan interventions should be personalized to the resident. During a phone interview on 05/01/2026 at 12:01 PM Nurse Practitioner #41 stated when they last saw the resident, they had been displaying behaviors or wandering, trying to exit the side door and pushing occupied wheelchairs. It was hard to engage the resident as they were non-verbal. Wandering was not an indication for Risperdal, and they did not agree with the method the resident was receiving the Risperdal currently; however, they were new to the resident and the facility. They were not made aware when the facility increased psychotropic medications for the residents. They were not aware the resident recently had an increase of their intramuscular Risperdal dose and did not agree with the increase if it was due to the resident's wandering as that was not an indication for use. Resident #134 should have personalized nonpharmacological interventions on their care plan. Nonpharmacological interventions should always be prioritized over medication. During a phone interview on 05/01/2026 at 12:32 PM Social Worker #49 stated their involvement with residents who had behaviors was minimal. They did the mood care plan and made sure the psychiatric services saw them. They coordinated with the nurse manager to make sure they were aware of the behaviors. The psychiatric nurse practitioner was typically involved in psychotropic medication changes and approving those changes. They were aware of Resident #134's increased behaviors but did not have any involvement besides knowing the resident had behaviors. 10 New York Codes, Rules, and Regulations 415.12		

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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 Enteral 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)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for two (2) of 13 kitchens (Cottages 10 and 11 kitchens). Specifically, Cottage 10 kitchen had undated and expired food items; and Cottage 11 had expired food in the pantry refrigerator and food was out of acceptable temperature range. Findings include: The facility policy Food and Supply Storage, last revised 01/2026, documented all food and non-food items and supplies used in food preparation would be stored in such a manner to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Food would be discarded past the use-by or expiration date. Cottage 10: The following observations of the Cottage 10 kitchen were made on 04/27/2026 at 10:21 AM: -the refrigerator contained one opened 21-ounce carton of honey thick milk with a best used by date of 01/14/2026. -the refrigerator contained one undated tin foil covered cardboard carton of wilted salad was in the refrigerator. -Two unopened 32-ounce cartons of honey thick milk with a best used by date of 01/14/2026 and 04/04/2026 were on the shelf in the storage area. -Two unopened 46-ounce cartons of honey thick apple juice with a best used by date of 04/07/2026 and 04/26/2026 were in the panty area. During an interview on 04/27/2026 at 10:39 AM, Food Service Aide #34 stated the cook was responsible for ensuring all items were labeled and dated and the dietary department was responsible for removing expired items. During an interview on 04/27/2026 at 10:50 AM, [NAME] #35 stated it was the cook's responsibility to ensure all food items were labeled and dated and they were supposed to check at the beginning of their shift. During an interview on 04/28/2026 at 12:21 PM, Dietary Supervisor #36 stated the best used by date meant the item needed to be used by that date and it was expired if it was kept past that date. Nursing staff were responsible for dating open drinks, monitoring dates and removing drinks that were expired. Dietary staff were responsible for dating food items, monitoring dates, and removing food items that were expired. All items should be checked daily and removed if they were not dated or labeled. Cottage 11 The April 2026 pantry refrigerator log for Cottage 11 documented the following: -On 04/02/2026 at 9:00 AM the refrigerator was at 43 degrees Fahrenheit with no follow up temperature at 2:00 PM. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 04/15/2026 the refrigerator was at 46 degrees Fahrenheit at 9:00 AM and 52 degrees Fahrenheit at 2:00 PM. Management was informed. -On 04/18/2026 the refrigerator was at 44 degrees Fahrenheit at 9:00 AM. -On 04/19/2026 the refrigerator was at 53 degrees Fahrenheit at 9:00 AM. -On 04/21/2026 the refrigerator was 50 degrees Fahrenheit at 8:00 AM. -On 04/26/2026 the refrigerator was at 45 degrees Fahrenheit at 7:30 AM. -On 04/27/2026 the refrigerator was in defrost mode at 9:00 AM. The following observations were made in Cottage 11 on 04/27/2026: -At 11:03 AM the resident refrigerator in the kitchen had boiled eggs, turkey, and ham lunch meat in the drawer with an expiration date of 04/26/2026. -At 11:11 AM the large, prepped meal refrigerator in the entrance alcove to the kitchen read 55 degrees Fahrenheit on both the external refrigerator thermometer and the independent thermometer inside. The refrigerator contained a tray of hot dogs, a tray of baked beans, a tray of carrots, a yogurt container, and a 2 liter bottle of soda. -At 11:18 AM the small refrigerator under the ice machine had a container of apricots with an expiration date of 03/06/2026. During an observation and interview on 04/27/2026 at 11:08 AM [NAME] #50 stated no residents consumed the boiled eggs, turkey, or ham out of the refrigerator that morning. The items were supposed to be discarded on the day they expired. The large, prepped meal refrigerator had been having problems holding temperature. It was logged on the temperature sheet, reported and management was aware. They were unsure how long the carrots, hot dogs, and baked beans were in the refrigerator as they were dropped off at different times. The baked beans and hot dogs were for dinner, and the carrots were for lunch. They were placed in the refrigerator frozen and were then heated up prior to meal service. [NAME] #50 took the temperature of the tray of carrots with a thermometer after removing them from the 55-degree Fahrenheit fridge. The carrots measured 62 degrees Fahrenheit. They stated they did not believe the apricots expired on 03/06/2026 but they should not have been in the refrigerator with that date. During an interview on 05/01/2026 at 12:56 PM the Director of Environmental Services stated maintenance requests were able to be made at any time, and the kitchen had its own sign on for the system. Food service was responsible for checking the refrigerator temperatures and reporting any issues. Monday, 04/27/2026 was the first time they were informed Cottage 11 had issues with the refrigerator. During an interview on 05/01/2026 1:06 PM Assistant Director of Food Service #52 stated they were covering for the current Director of Food Service for the day. They stated all the food that came out of the main kitchen had orange labels with the date and time it was prepared and the date the product expired/should be discarded. Everything in the refrigerators should either have an orange label or a handwritten label. The food should be discarded at the end of the day of the labeled discard date. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There should not be expired items from the previous day still in the refrigerator or items with an expiration date of March 2026. During a phone interview on 05/01/2026 at 1:11 PM the Food Service Director stated the management team did weekly rounds and they checked the refrigerators and the temperature sheets. An out-of-temperature refrigerator should be reported as soon as it was noticed. They usually recommend the staff wait 30 minutes to see if the temperature drops back into the appropriate range. If it did, they kept an eye on the refrigerator. If it did not, a work order was submitted. Staff should be checking the refrigerator temperature prior to putting food in it and they should not be putting food into a refrigerator that was 55 degrees. They were aware the refrigerator was in and out of temperature, but it always dropped back into the correct temperature range. They were not aware the temperature was 55 degrees on Monday until they were notified, and they could not recall any other 50 and above temperatures that happened back-to-back in a day. 10 New York Codes, Rules and Regulations 415.14(h)		

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, record review, and interviews, the facility failed to ensure a process was in place for residents to have their grievances addressed for 138 of 138 residents residing in the facility. Specifically, information on how to file a grievance and grievance forms was not available to the residents and the facility did not have a process for residents to file an anonymous grievance in 13 of 13 Cottages; and three (3) of three (3) anonymous residents present at the resident group meeting stated they did not know if there were grievance forms or where they were located, their right to file grievances anonymously, who the Grievance Officer was, and there was not always follow up on how their concerns were addressed. Findings include: The facility policy Grievance Management, last reviewed 04/2025, documented residents would be advised of their right to voice a complaint and the process for doing so upon admission and the information would also be posted throughout the facility. Complaints may be communicated orally or in writing to any member of the staff. For each complaint received the staff member was to complete a Complaint Record documenting the date of the complaint, name of the individual, the relationship with the resident, the resident, the nature of the complaint including a request for a written response, requested action sought, and the preferred method of response. The staff would give it to their immediate supervisor who would then forward it on to the Grievance Officer. The Grievance Officer would log and track the resolution and distribute the complaint to the Administrator, Director of Nursing and appropriate members of management who would complete the investigation within 5 business days. The Grievance Officer would notify the complainant in the manner requested. If the complaint could not be resolved within 5 business days, the management staff member was to contact the complainant to let them know additional time was needed. The 2025 Grievance Log documented seven (7) grievances for the year. There were no documented grievances for 2026. During a resident group meeting on 04/27/2026 at 2:07 PM, three (3) anonymous residents stated the facility listened to their concerns, but they did not tell the residents what they were going to do or were doing to address their concerns. They did not know if there was a grievance process, if there was a formal process to write down a concern, how to file a grievance, or who the Grievance Officer was. The following cottages were observed to have no signs on the process for filing a grievance, who the Grievance Officer was, grievance forms available to residents, or a way to file a grievance anonymously:- Cottage 11 on 05/01/2026 at 1:23 PM- Cottage 21 on 05/01/2026 at 1:26 PM- Cottage 31 on 05/01/2026 at 1:29 PM- Cottage 10 on 05/01/2026 at 1:35 PM During an interview on 05/01/2026 at 9:57 AM, Certified Nurse Aide #19 stated they did not know what the grievance process was for the facility or who the Grievance Officer was. During an interview on 05/01/2026 at 9:48 AM, Licensed Practical Nurse #32 stated they did not know what facility's grievance policy was or how to file a grievance for a resident or family member's concern. They also did not know who the Grievance Officer was. During an interview on 05/01/2026 at 11:09 AM, Registered Nurse Manager #20 stated if a resident complained to a certified nurse aide the certified nurse aide should notify the nurse manager. They should obtain as much information as they could about their concern and give it to the social worker. The social worker would then complete the investigation. They did not know if there was a way to file a grievance anonymously. They were unsure if there were grievance forms for residents and/or families to fill out, but they did not have copies in the cottage. If they had forms, it was likely on the facility's electronic share drive. During an interview on 05/01/2026 at 12:46 PM, the Director of Resident Services stated any concern brought up was supposed to be written up on a grievance form and the investigation was completed by the appropriate department. The Grievance Officer should ensure it was completed, and a resolution was given to the resident. All staff had access to the grievance form through the electronic share drive. There was not a way for residents or families to file a grievance anonymously. Residents and families did not have access to the grievance form without asking staff. They were not aware it was a (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER The Cottages at Garden Grove, A Skilled Nrsng Comm		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	resident right to be able to file a grievance anonymously. There were no signs posted in the cottages regarding the grievance process, how to file a grievance, and who the Grievance Officer was but some cottages had a binder on resident rights. During an interview on 05/01/2026 at 1:50 PM the Administrator stated there was a grievance form that residents, families, or staff could fill out if there was a concern or issue. If a staff member completed a grievance for a resident or family they should start the investigation. If it could not be resolved, the grievance was forwarded up to a higher level. If a resident requested a grievance form staff could make them a copy of the form. Some of the clinical care offices in the cottages kept a copy of the grievance forms. There was a binder in each cottage before the pandemic, but they were removed. The residents and families could also contact the Ombudsman with any concerns. A resident could file an anonymous grievance by asking for a form, leave their name off when filling it out and leave it in the clinical care office. They were aware it was a resident right to file a grievance and to be able to file one anonymously. 10 New York Codes, Rules, and Regulations 415.3(C)(1)(ii)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER The Cottages at Garden Grove, A Skilled Nrsng Comm		STREET ADDRESS, CITY, STATE, ZIP CODE 5460 Meltzer Court Cicero, NY 13039	
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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interviews, the facility failed to ensure the results of the most recent Federal and State surveys were posted in a place readily accessible where individuals who wished to examine the survey results did not have to ask for them for 5 of 13 cottages (Cottages 10, 11, 21, 31, and 77). Specifically, the facility State survey results binders in Cottages 10, 11, 21, 31, and 77 were on a mantle shelf that was not readily accessible to residents in wheelchairs or were partially obscured by other items and not able to be easily seen by residents and families without asking for assistance. Findings Include: The New York State Department of Health Your Rights as a Nursing Home Resident in New York State documented residents had the right to read the results of the most recent State and Federal inspection survey and the facility's plan to correct any violations. During an anonymous resident group meeting on 04/27/2026 at 2:07 PM, four (4) residents stated they had never seen any previous survey results and did not know where they were located. The following observations were made of the facility State inspection binders: -In Cottage 10 on 04/28/2026 at 12:14 PM, the binder was on top of the mantle shelf behind the sign that documented the survey binder was on the lower shelves below and on 05/01/2026 at 1:35 PM, it was on the top mantle shelf against the back wall with a sign in front of it indicating the binder was on a lower shelf. -In Cottage 11 on 04/28/2026 at 12:44 PM, the binder was on top of the mantle shelf cabinet above average standing head height against the wall to the right of the television not accessible to residents in wheelchairs without assistance; and on 05/01/2026 at 11:01 AM it was on the top mantle shelf not at a wheelchair accessible level. -In Cottage 21 on 04/28/2026 at 12:50 PM, the binder was on the top mantle shelf above average head height and not at a wheelchair accessible height. It was partially blocked by a sign that indicated the State inspection binder was on the shelves below. On 05/01/2026 at 11:26 AM, the binder was on the top mantle shelf not at an accessible level for residents in wheelchairs. -In Cottage 31 on 04/28/2026 at 1:35 PM the binder was on the top mantle shelf behind a sign that documented the survey results were in a binder on the bookshelf below. The sign was obstructed by a vase of artificial flowers, and the binder was behind the sign. On 05/01/2026 at 1:29 PM, the binder was on the top mantle shelf, not within accessible reach, and behind the sign that stated it was on the lower shelf. -In Cottage 77 on 04/29/2026 at 10:54 AM, the binder was on the shelf inside of a closed cabinet 4 feet up from the ground. During an interview on 05/01/2026 at 9:57 AM, Certified Nurse Aide #19 stated they did not know where the State inspection binder was. Upon observing where the binder was located on the top shelf above average head height, they stated they did not believe it was accessible to residents. During an interview on 05/01/2026 at 11:09 AM, Registered Nurse Manager #20 stated the previous State inspections were posted in the common area of the cottage. The binder was kept around the mantle area, and the residents could ask to see it. The book was not at typical resident accessible height, and they would have to ask someone to see the results. During an interview on 05/01/2026 at 1:50 PM, the Administrator stated the most recent State inspections were in a binder in each cottage accessible to the residents. The State inspections should be kept on the bookshelf within reach of the residents or by the activity area. They were unaware the State inspection binders were kept on the top mantle shelf and not at a wheelchair accessible level. 10 New York Codes, Rules and Regulations 415.3(1)(c)(1)(v)		

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NAME OF PROVIDER OR SUPPLIER The Cottages at Garden Grove, A Skilled Nrsng Comm		STREET ADDRESS, CITY, STATE, ZIP CODE 5460 Meltzer Court Cicero, NY 13039	
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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide the resident and their representative with a summary of their baseline care plan that included initial goals, a summary of medications and dietary instructions, and services and treatments to be administered for one (1) of one (1) resident (Resident #14) reviewed. Specifically, there was no documented evidence Resident #14 and their representative were informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. Findings include: The facility policy Comprehensive Care Plans, revised 04/2025, documented each resident would have an individualized interdisciplinary plan of care completed within 48 hours of admission. Resident #14 was admitted to the facility on [DATE] with diagnoses including left hip fracture. The comprehensive care plan, initiated 04/06/2026, documented the resident was alert and oriented and was independent in decision making. Interventions included encourage their involvement in the care planning process. During an interview on 04/28/2026 at 1:27 PM, Resident #14 stated they and their two children had a meeting with several other staff members in the past month, but they did not recall receiving a copy of their care plan or their physician orders. During an interview on 04/28/2026 at 2:32 PM, Registered Nurse Manager #3 stated care plans were initiated on admission by the nurse managers, and they held 72-hour care plan meetings. They never provided residents with a copy of their baseline care plan and were never told they had to. They did not give Resident #14 a copy of their baseline care plan. Their first care plan meeting was 04/20/2026; they did not have a 72-hour care plan meeting due to a family death. During an interview on 05/01/2026 at 11:26 AM, the Director of Nursing stated the facility did not complete baseline care plans. They had been at the facility for 5 years and during that time baseline care plans were not printed and given to the residents. They were not aware that should happen. 10 New York Codes, Rules and Regulations 415.11		