

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2026
NAME OF PROVIDER OR SUPPLIER Franklin Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 142 27 Franklin Avenue Flushing, NY 11355	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the residents' right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. This was evident for one (1) of six (6) residents reviewed for Activities of Daily Living out of a total of 38 sampled residents. Specifically, Resident #238 was observed to have their call bell out of reach on multiple occasions. The findings include: The facility policy titled Call Bell - Nurse Call System, with an approval date of 06/11/2025 stated that the facility is committed to maintaining a functional and accessible call bell system in all resident rooms, bathrooms, and common areas, in compliance with federal regulations. The policy also stated that all residents' rooms, bathrooms, and bathing areas must have accessible call devices within reach of the resident, including when lying on the floor. Resident #238 was admitted to the facility with diagnoses including osteomyelitis (a bone infection), diabetes mellitus (a chronic condition that occurs when the body cannot properly use blood sugar), and hypertension (high blood pressure). The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #238 had intact cognition and had functional impairment on both sides of both upper and lower extremities. On 05/13/2026 at 11:06 AM, Resident #238 was observed in bed. Resident's call bell was observed to be wound up and hanging on the wall, out of reach of the resident. Resident #238 was interviewed and stated very often they do not know where their call bell is. Resident #238 also stated that they are able to use the call bell and have used the call bell when it has been available but has resorted to just calling out for the nurses when they need help. On 05/14/2026 at 11:16 AM, Resident #238 was observed in bed. Resident's wheelchair was noted to be placed next to the bed, facing the wall. The call bell was observed to be on the floor, under the wheelchair and out of reach of the resident. On 05/19/2026 at 12:37 PM, Certified Nursing Assistant #9 was interviewed and stated that it is the responsibility of the certified nursing assistants to ensure the call bell is within reach of the resident after giving care or changing the sheets. On 05/19/2026 at 12:40 PM, Registered Nurse #7 was interviewed and stated that Resident #238 used to use their call bell more often when they had a private room but now tends to call out for the registered nurses by name. Registered Nurse #7 was unsure if resident was calling out as a preference of because the call bell was not available. Registered Nurse #7 stated that when Resident #238 calls out, they answer and assist the resident, but they do not always check that the call bell is within reach. On 05/20/2026 at 10:03 AM, the Director of Nursing was interviewed and stated call bells should be within the reach of the resident, and all nursing staff are responsible for ensuring the call bell is within reach of the resident. 10 New York Code, Rules and Regulations 415.5 (e)(1)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on record review, observations, and interviews, the facility to ensure it promoted and facilitated resident self-determination through support of resident choice. This was evident for two (2) residents (Resident #13 and #188) of six (6) residents reviewed for Activities of Daily Living out of 38 total sampled residents. Specifically, Resident #13's and Resident #188's bathing preferences were not honored. The findings include: The facility policy titled Activities of Daily Living with an approval date of 02/20/2026 stated the facility will ensure that bathing and showering practices, including frequency, method, timing, and assistance, are individualized, clinically appropriate, and aligned with each resident's preferences and needs. 1. Resident #13 had diagnoses which included paraplegia (paralysis or severe weakness of the lower half of the body), hypertension (high blood pressure), and peripheral vascular disease (blood vessels outside the heart and brain become narrowed or blocked). The Significant Change Minimum Data Set assessment (a resident assessment tool) dated 11/05/2025, documented it is somewhat important for Resident #13 to choose between a tub bath, shower, or sponge bath. The Quarterly Minimum Data Set Assessment (a resident assessment tool) dated 05/02/2026, documented Resident #13's cognition was intact, and resident required moderate assistance from staff for showering. On 05/13/2026 at 9:36 AM, Resident #13 was interviewed and stated they prefer a shower every day and they are only allowed a shower once a week. Resident #13 also stated they spoke to the nursing supervisor and Director of Nursing, and they were told they can only take a shower once a week. A comprehensive care plan for Activities of Daily Living with a last reviewed date of 04/23/2026 documented that Resident #13 required moderate assistance from staff for bathing/showering. The Resident Nursing Instructions dated 04/01/2026 to 05/19/2026 documented Resident #13's bathing type was shower, and the bathing schedule was every week on Friday during the 3:00 PM to 11:00 PM shift. The Resident Certified Nursing Assistant Documentation Record dated 04/01/2026 to 05/19/2026, documented Resident #13 received a shower once per week. Review of progress notes dated 04/01/2026 to 05/16/2026 revealed no documented evidence that Resident #13's shower preference was addressed. On 05/15/2026 at 3:16 PM, Certified Nursing Assistant #8 who works the 3:00 PM to 11:00 PM shift was interviewed and stated Resident #13 is scheduled for showers every Friday on the 3:00 PM to 11:00 PM shift. Certified Nursing Assistant #8 also stated all residents are scheduled showers one time a week either on the day or evening shift. Certified Nursing Assistant #8 further stated if a resident needs an extra shower, the family member has to speak to the nursing supervisor so they can schedule the shower and inform the staff. If the resident is alert, they could give them a shower anytime they request but it all depends on timing. Certified Nursing Assistant #8 stated every resident on the assignment has a shower scheduled so the shower would have to be squeezed in as long as it is not during another resident's scheduled shower. On 05/15/2026 at 3:27 PM, Licensed Practical Nurse #4 who works the 3:00 PM to 11:00 PM shift was interviewed and stated residents are scheduled showers once a week. If a resident wants to take a shower every day and they require one (1) staff to assist them, then they can take a shower every day. Licensed Practical Nurse #4 also stated if the resident requires total care and they repeatedly ask for a shower every day, they can have a shower more often, but they do not know how often. Licensed Practical Nurse #4 further stated if the resident looks like they need a shower their aide will give them a shower. 2. Resident #188 had diagnoses of Alzheimer's disease (progressive brain disease that damages memory and thinking), cerebral infarction (blood flow to part of brain is blocked), and hypertension (high blood pressure). The Quarterly Minimum Data Set (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment (a resident assessment tool) dated 04/27/2025 documented Resident #188's cognition was severely impaired, and they were dependent on staff for showering. On 05/18/2026 at 3:02 PM, Resident #188's Representative was interviewed and stated Resident #188 receives a shower one (1) day a week. Resident #188's Representative also stated they requested more showers when Resident #188 was admitted , and the nursing supervisor stated Resident #188 can only have a shower one (1) time per week. Resident #188's Representative further stated they wish that Resident #188 could have more showers, so they can feel more comfortable. A comprehensive care plan for Activities of Daily Living with a last reviewed date of 04/27/2026 documented that Resident #188 was dependent on staff for bathing/showering. The Resident Nursing Instructions dated 04/01/2026 to 05/19/2026 documented Resident #188's bathing type was shower, and the bathing schedule was every week on Sunday during the 7:00 AM to 3:00 PM shift. The Resident Certified Nursing Assistant Documentation Record dated 04/01/2026 to 05/19/2026, documented Resident #188 received a shower once per week. Review of progress notes dated 04/01/2026 to 05/16/2026 revealed no documented evidence that Resident #13's shower preference was addressed. On 05/19/2026 at 10:26 AM, Certified Nursing Assistant #6 was interviewed and stated Resident #188 has a scheduled shower day on Sundays. Certified Nursing Assistant #6 also stated If necessary and a resident is really messed up, then they will receive a shower. Certified Nursing Assistant #6 further stated they were unaware that Resident #188's family preferred more than one (1) shower a week. On 05/19/2026 at 10:40 AM, Licensed Practical Nurse #3 was interviewed and stated Resident #188 is scheduled for showers on Sunday mornings. Licensed Practical Nurse #3 also stated Resident #188 receives a shower one (1) time a week and in between they receive bed baths each shift. Licensed Practical Nurse #3 further stated all residents receive showers one (1) time a week, and there are some residents who request more showers, and they will fit the shower into the schedule. Licensed Practical Nurse #3 stated they were unaware Resident #188's family member requested extra showers. On 05/19/2026 at 11:31 AM, Registered Nurse #5, who is also the supervisor, was interviewed and stated all residents receive showers one (1) time per week and Resident #188's shower day is Sunday morning. Registered Nurse #5 also stated Certified Nursing Assistants also give showers as needed. On 05/19/2026 at 3:09 PM, the Director of Nursing was interviewed and stated residents are scheduled one (1) shower a week and as needed. The Director of Nursing also stated if the resident or a resident's family request a shower, the aide has to give the shower. The Director of Nursing further stated they were unaware residents were not receiving extra showers when they were requested. 10 New York Codes, Rules and Regulations 415.5(b)(1-3)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure that a resident is free from physical restraints imposed for discipline or staff convenience and not required to treat the resident's medical symptoms. This was evident for two (2) residents (Resident #109 and Resident #184) of two (2) residents reviewed for Physical Restraints out of 38 sampled residents. Specifically, 1). Resident #184 was observed on several occasions, lying on a perimeter mattress and, 2). Resident #109 was observed on two occasions, lying on a perimeter mattress with an armchair and pillow wedged on the left side of the bed, in between the upper part of resident's bed and the window area. The findings include: The facility's policy titled Use of Restraints with an approval date of 03/06/2026 stated that a restraint is any physical or mechanical device or intervention that restricts a resident's freedom of movement or access to his/her body. The policy also stated that interventions/devices that may be considered restraints include but are not limited to chairs that prevent movement and cushions used to restrict mobility. The policy further stated devices that do not restrict purposeful movement and instead provide protective positioning or sensory/tactile cues are not considered restraints. These include but are not limited to perimeter mattresses. 1. Resident #184 had diagnoses which included Cerebrovascular Accident (a sudden disruption in blood flow to the brain which can lead to complications) , Aphasia (language condition that affects the ability to communicate effectively), Hemiplegia (paralysis or weakness affecting one side of the body), and Seizure Disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #184 had severely impaired cognition, required dependent assistance of staff for personal hygiene and transfer, and had limited range of motion on one side of upper extremity and both sides of lower extremity. On 05/13/2026 at 11:40 AM, Resident #184 was observed in bed, alert and awake. Resident #184 appeared confused, was unable to make verbal or nonverbal communication when called by their name. Resident #184 was observed with a perimeter mattress on top of bed, which was raised along both sides, the top and the bottom of the mattress. The mattress also appeared to have built-in side bolsters, while the middle surface is flat. On 05/14/2026 at 09:55 AM, Resident #184 was again observed in bed with a perimeter mattress. Review of physician orders revealed there was no order for the use of a perimeter mattress. The Restraint/Device Assessment Evaluation dated 12/06/2024 document that Resident #184 was unable to understand and recall purpose and safe use of device, and why alternatives were inappropriate or ineffective to prevent use of restraint, and resident continues to slide to the edge of the bed without the perimeter. There was no further assessment completed for Resident #184. The (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Comprehensive Care Plan titled Occurrence and at Risk for Occurrence with effective date of 02/29/2021, and last revised on 01/01/2026, documented the Resident become frail, experience weakness of limbs, loss of muscle strength or coordination; may also be unable to think, understands as clearly as once could ,unable to adapt to new environment/ limited functional status & performance; has adverse effect of medication, this put the resident at risk for fall and injury. Interventions and measures are placed to monitor resident to minimize the risk of occurrence and injury. Interventions include, provide resident a concave/scoop mattress or perimeter mattress cover. On 05/15/2026, at 11:57 AM, an interview was conducted with Certified Nursing Assistant #1 who stated Resident #184 is confused and cannot follow simple instruction. Certified Nursing Assistant #1 also stated Resident #184 is totally dependent on staff and transferred with a Hoyer lift. Certified Nursing Assistant #1 further stated Resident #184 had been on perimeter mattress for a long time, and they believed it was to prevent fall. Certified Nursing Assistant #1 monitoring the use of a perimeter mattress is not included in their daily tasks in the electronic medical record. On 05/15/2026 at 12:01 PM, an interview was conducted with Licensed Practical Nurse #1 who stated Resident #184 is confused and cannot make their needs known to staff. Licensed Practical Nurse #1 also stated Resident #184 had no awareness of their surroundings and sometimes moves their legs to the side of bed, attempting to get off bed, so the perimeter mattress is used to protect them. On 05/15/2026 at 12:30 PM, an interview was conducted with Registered Nurse #1, the Charge Nurse, who stated that resident is confused, stated Resident #184 is nonverbal, is transferred with a mechanical lift with two staff and has had no recent falls. Registered Nurse #1 also stated Resident #184 uses a perimeter mattress for fall safety, and they are not responsible for the ongoing assessment of use of the perimeter mattress. On 05/18/2026 at 12:24 PM, an interview was conducted with Registered Nurse #2, the Nursing Supervisor, who stated that the purpose of the mattress is to prevent falls. Registered Nurse #2 also stated Resident 184 had a diagnosis of seizures, was confused and had weakness of their body, and they could fall. Registered Nurse #2 further stated they reviewed Resident #184's chart and realized that the last Restraint/Device Assessment Evaluation was completed on 12/06/2024. Registered Nurse #2 concluded that there should have been assessments completed every quarter, and the facility usually does not have physician orders for a perimeter mattress. On 05/18/2026 at 01:14 PM, an interview was conducted with Registered Nurse #3, the Nurse Educator, who stated that the perimeter mattress is a sensory mattress, which alerts the resident and provides sensory feedback for the edges of the bed to prevent them from getting out of bed. Registered Nurse #3 also stated that once the resident pulls to the side of the bed and their body touches the mattress, it gives them a sensation and will prevent them from coming out of the bed. Registered Nurse #3 further stated that a restraint/device assessment is needed every quarter and annually, but they could not explain why there was no ongoing assessment since 2024. Registered Nurse #3 stated that the facility do not have physician's order for the use of perimeter mattress. On 05/20/2026 at 11:50 AM, an interview was conducted with the Director of Nursing who stated that (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	perimeter mattresses were never identified as a restraint, the mattress is there for safety awareness and as a bed boundary. The Director of Nursing also stated that an ongoing restraint/device assessment should be conducted every quarter and annually, but they could not explain why the assessment was missed. 2. Resident #109 had diagnoses which included quadriplegia (paralysis or severe weakness in all four limbs), neuropathic pain (burning, tingling, shooting, or electric shock sensations caused by damage or problems in the nerves), and muscle spasticity (muscles move in an involuntary, sometimes jerky way). On 05/13/2026 at 10:18 AM and on 05/15/2026 at 9:40 AM, Resident #109 was observed lying on a perimeter mattress with an armchair and pillow wedged on the left side of the bed, in between upper part of the resident's bed and the window. The Significant Change Minimum Data Set assessment (a resident assessment tool) dated 03/27/2026 documented Resident #109 had intact cognition, was dependent on staff for bed mobility and transfers, and no restraints used. What was documented for ROM? The Restraint/Device Assessment Evaluation dated 02/17/2026 documented Resident #109 had been assessed, and the purpose of the perimeter mattress would be to provide sensory feedback for edges of bed. Resident #109 was able to understand and recall purpose for and safe use of device. The device was not considered a restraint because it does not prevent purposeful exit from and entry to bed, does not restrict access to body, and does not restrict purposeful movement. A comprehensive care plan titled Occurrence and at risk for occurrence with a last reviewed date of 02/20/2026 documented Resident #109 had a fall out of bed on 02/17/2026 with no injury. Interventions included provide Resident #109 with a perimeter mattress cover to maintain bed boundaries, floor mats on both sides of bed, and bed at lowest position. Review of the progress notes did not reveal any education provided to Resident #109's spouse regarding the unsafe practice of wedging the chair and pillows in between bed and window area. There was no documented evidence of a Physician's order for the use of a perimeter mattress and of the medical necessity for use of the perimeter mattress. On 05/14/2026 at 11:34 AM, Resident #109's spouse was interviewed and stated they visit Resident #109 every day until about 11:00 PM when Resident #109 falls asleep. Resident #109's spouse also stated Resident #109 fell out of bed in the past and they are afraid Resident #109 will have another fall. Resident #109's spouse further stated they set up the chair before they leave at night, so the back of the chair is against the bed to prevent Resident #109 from falling. Resident #109's spouse further stated a staff member on the second floor showed them how to set up the chair like that and they do not know their name. On 05/15/2026 at 11:35 AM, Certified Nursing Assistant #2 was interviewed and stated Resident #109's spouse is scared Resident #109 will fall and therefore places the chair against the bed to (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	prevent Resident #109 from falling. Certified Nursing Assistant #2 stated they think Resident #109 needs side rails instead of the mattress pillows. On 05/15/2026 at 12:09 PM, Licensed Practical Nurse #2 was interviewed and stated Resident #109 does not try and get out of bed. Licensed Practical Nurse #2 also stated Resident #109's spouse wedges the armchair in between the bed and the window area and informed them they put the chair there to feel better when they leave. Licensed Practical Nurse #2 further stated they told Resident #109's spouse to position the chair so they can reach the resident to administer medications. Resident #109 has not had a fall on this floor. On 05/15/2026 at 2:49 PM, Registered Nurse #2, who is the supervisor, was interviewed and stated they thought Resident #109's spouse moved the chair by the bed for space when they were visiting. Registered Nurse #2 also stated Resident #109 could hurt themselves on the wedged chair if they fell out of the bed. Registered Nurse #2 further stated Resident #109 has a perimeter mattress for sensory feedback, so if they roll it will alert them, and the perimeter mattress does not prevent Resident #109 from getting out of bed. Registered Nurse #2 stated there is no doctor's order in Resident #109's medical record for the perimeter mattress, and there is an assessment for the perimeter mattress dated 02/17/2026 that documents Resident #109 will continue to slide to edge of bed without the mattress. Registered Nurse #2 also stated the perimeter mattress is not considered a restraint because it does not restrict purposeful movement and does not prevent exit or entry to bed. On 05/19/2026 at 2:58 PM, the Director of Nursing was interviewed and stated the chair is not supposed to be against the bed because there is an injury risk. The Director of Nursing also stated the perimeter mattress is not a restraint because Resident #109 can get over the mattress since it is not high. The Director of Nursing also stated the perimeter mattress is for Resident #109 to feel and realize that they are at the edge of the bed, and they have a bedside mat and very low bed for safety as well. 10 New York Codes, Rules, and Regulations 415.4(a) (2-7)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that residents comprehensive care plans were reviewed and revised to reflect the resident's status after each assessment. This was evident for one (1) resident (Resident #68) of two (2) residents reviewed for Activities, and one (1) resident (Resident #4) of two (2) residents reviewed for Urinary Catheter, out of 38 sampled residents. Specifically, 1). the comprehensive care plan for Activities for Resident #68, and 2). the comprehensive care plan for bladder care for Resident #4 were not revised after each assessment. The findings include but were not limited to: The facility policy titled Care Planning-Conferences with an approval date of 03/05/2026 documented the facility shall develop, implement, maintain, and timely update a comprehensive, interdisciplinary, and person-centered care plan for each resident based on thorough assessment of the resident's clinical needs, functional status, and individual preferences, to ensure the provision of care and services necessary for each resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being, with active participation of the resident and/or their representative, and ongoing review and revision on Admission, Quarterly, Annually, and whenever there is a significant change in condition, resident preferences, or effectiveness of interventions. 1. Resident #68 had diagnoses of cerebral vascular accident (brain cells damaged due to blocked blood flow or burst blood vessel), vascular dementia (memory loss and thinking decline caused by reduced blood flow to the brain), and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set assessment (a resident assessment tool) dated 02/10/2026 documented Resident #68 was severely cognitively impaired. The Care Plan with focus Activities was effective on 03/18/2024 and the last review note was dated 11/20/2024. There was no documented evidence that the Activities Care Plan had been reviewed and revised since the Annual assessment on 12/04/2024. On 05/20/2026 at 10:08 AM, the Director of Therapeutic Recreation was interviewed and stated that usually care plans are updated or reviewed quarterly and on an as needed basis. The assigned recreation leader is responsible to update and review the care plans, but they were out for a while. The Director of Therapeutic Recreation also stated they have been completing the activity assessments timely but got sidetracked. The Director of Therapeutic Recreation further stated they are responsible to check to make sure the activities care plans are updated or reviewed. 2. Resident #4 was admitted to the facility with diagnoses including diabetes mellitus (a condition where the body cannot properly use blood glucose), and hypertension (high blood pressure). (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #4 was severely cognitively impaired and dependent on staff for toileting hygiene. A physician's order dated 05/12/2026 documented Amoxicillin/Clavulanate 875/125 milligrams, give 1 tablet every 12 hours by oral route for 10 days for urinary tract infection. The care plan titled, Bladder elimination/indwelling catheter/genitourinary status was initiated on 12/21/2021. The last update/review note for the care plan was dated 12/2/2024. There was no documented evidence that the care plan was reviewed or revised after each assessment On 05/19/2026 at 10:12 AM, Registered Nurse #7 was interviewed and stated that care plans are initiated for recurring conditions, such as skin conditions or recurring infections. Registered Nurse #7 also stated that the nursing supervisors are responsible for updating the care plans, but that care plans should be updated quarterly. Registered Nurse #7 further stated that given Resident #4 had a urinary tract infection, the care plan should have been updated since December 2024. On 05/19/2026 at 12:19 PM, Registered Nurse #10, who is the nursing supervisor, was interviewed and stated it is their responsibility to update care plans. Registered Nurse #10 also stated that care planning meetings involve the resident and/or the resident's representative, as well as the interdisciplinary team including nursing, rehabilitation, dietitian, and social worker. Registered Nurse #10 further stated that any updates to care, including monitoring and evaluation of interventions should be documented in the care plan. Registered Nurse #10 stated they had not reviewed and/or updated the care plans as often as they would have liked to. Registered Nurse #10 reviewed the electronic medical record and stated that the care plan for bladder elimination should have been updated, especially since Resident #4 recently had a urinary tract infection. On 05/20/2026 at 10:03 AM, the Director of Nursing was interviewed and stated that care plans should be updated quarterly, or if there is a significant change in the resident's condition. The Director of Nursing further stated that the nurses and the nursing supervisors may update the care plans. The Director of Nursing further expressed disappointment that care plans had not been updated in a timely manner. 10 New York Codes, Rules and Regulations 415.11(c)(1)		

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NAME OF PROVIDER OR SUPPLIER Franklin Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 142 27 Franklin Avenue Flushing, NY 11355	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interviews, and record review, the facility failed to ensure that services provided meet professional standards of quality. This was evident for two (2) residents (Residents #7 and #28) observed during Medication Administration. Specifically, 1) Registered Nurse #8 was observed administering intravenous medications without flushing the access line, and 2) Registered Nurse #7 was observed administering multiple medications via gastrostomy tube without flushing the tube with water before and after each medication. The findings include: The standard of practice for maintaining the patency of intravenous catheters, as defined by the Infusion Therapy Standards of practice published by the Infusion Nurses Society in 2024, dictates the administration of antibiotics via the sequence of, saline-administer-heparin-saline, is a standardized flushing sequence designed to maintain vascular access patency, prevent occlusion, and ensure safe medication administration. The standard of practice for preparing and administering medications via enteral tube, as defined by the American Society of Parenteral and Enteral Nutrition, in conjunction with the Institute of Safe Medication Practices' publication in 2022, is that the tube must be manually flushed with at least 15 milliliters of purified water before and after each medication. Medications should not be mixed together in order to prevent drug-drug interactions which can interfere with the intended therapeutic response or form precipitates that may clog the feeding tube. The facility policy titled, Intravenous Therapy, with an approval and implementation date of 11/2008, documented that the licensed nurse will observe all resident's safety and infection control principles in intravenous insertion and administration of intravenous infusion and medications. The administration of intravenous medication procedure detailed in the policy did not provide documented guidance to flush the access line to ensure the line remains clear with proper catheter function for safe medication delivery and for reduced risk of infection. The facility policy title, Feeding Tubes Enteral - Nutrition and Medication, with an approval date of 09/29/2025, documented that the facility will ensure that a resident who is fed by enteral feeding tube shall receive the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, significant regurgitation, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers, and to restore, if possible, normal feeding function. The Medications via Gastrostomy Tube: Guidelines for Administration, procedure detailed in the policy documented the administration procedure begins with thirty to fifty (30-50) milliliters of water flush. Then using a sufficient volume of fluid (which will depend on the individual medication), mix each medication with water, and pour into tube. Flush in between each medication with minimum ten to fifteen (10-15) milliliters of water. After last medication is administered, flush with thirty to fifty (30-50) milliliters of water. 1. Resident #7 was admitted to the facility with diagnoses including chronic lung disease, respiratory failure, and atrial fibrillation. The doctor's order with start date 05/10/2026 instructs midline flush using SASH (saline, antibiotic, saline, heparin) before and after administration of medication until complete and to schedule frequency as per antibiotic order. The physician's order with a start date of 04/26/2026 documented piperacillin-tazobactam 3.375-gram intravenous solution to be infused every six (6) hours for six (6) weeks. On 05/18/2026 at 11:30 AM, Registered Nurse #8 was observed preparing and administering piperacillin-tazobactam 3.375-gram in normal saline intravenously to Resident #7. Registered Nurse #8 mixed and prepared the medication and placed medication, two saline flushes, one heparin flush, one tubing set, and alcohol pads in a cleaned tray and proceeded to enter Resident #7's room. Registered Nurse #8 failed to flush the midline with saline prior to attaching the primed line of antibiotic. After administering the medication, Registered Nurse #7 threw away the supplies left on the tray and cleaned the tray. On 05/18/2026 at 4:34 PM, (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #8 was interviewed and stated that they performed the SASH order in the morning to check the patency of the midline. The further stated they forgot to flush the midline with saline prior to administering the intravenous antibiotic. On 05/19/2026 at 3:10 PM, Registered Nurse #11, the nursing supervisor for Unit Two (2), was interviewed and stated SASH order must be performed to ensure the patency of the midline, and it should be performed for each antibiotic administration. 2. Resident #28 was admitted to the facility with diagnoses including seizure disorder, malnutrition, and gastroesophageal reflux disease. On 05/19/2026 at 8:47 AM, Registered Nurse #7 was observed performing medication administration for Resident #28. Registered Nurse #7 was observed to appropriately prepare ten medications for administration. When initiating administration via gastrostomy tube, Registered Nurse #7 stopped the tube feed and administered approximately fifteen (15) milliliters of water. Then Registered Nurse #7 proceeded to administer each medication via gastrostomy tube one after the other, failing to flush the tube with water after each medication. After all medications were administered, Registered Nurse #7 poured approximately fifty (50) milliliters of water into the tube, then an additional forty (40) milliliters before restarting the tube feeding. On 05/19/2026 at 10:09 AM, Registered Nurse #7 was interviewed and stated that usually the gastrostomy tube would be flushed with water, then medications would be administered one by one, and finally the tube would be flushed with water at the end. They admitted that flushing between medications is done sometimes but admitted they did not flush between medications for Resident #28 because the resident was receiving a lot of medications. On 05/19/2026 at 12:19 PM, Registered Nurse #10, who is the nursing supervisor for Unit Three (3) was interviewed and stated that when administering medications via gastrostomy tube, first the tube would be flushed with at least thirty (30) milliliters of water, the medications may be administered, and then the tube would be flushed again with at least thirty to fifty (30-50) milliliters of water. They also stated that water should be flushed between medications to ensure that there is no residual medication in the tube. They further stated that the facility's policy states that water flushed should be performed between medications. On 05/20/2026 at 10:30 AM, Registered Nurse #6 was interviewed and stated that water flushes between medications during medication administration does not require an order because it is part of the facility's protocol. On 05/20/2026 at 10:03 AM, the Director of Nursing was interviewed and stated SASH order must be performed for every antibiotic administered intravenously. The Director of Nursing stated that for gastrostomy tube medication administration, thirty (30) milliliters of water should be used to initially flush the tube, then medications may be administered one at a time with water flushes in between. If there is noticeable medication left in administration cup, then more water should be used to dissolve the medication, and it should be administered. This should be done to ensure that the full intended dose has been administered. After medications are given, the tube should be flushed again with water. They also stated that gastrostomy tube medication administration had recently been in-serviced for nursing staff about a month ago. On 05/20/2026 at 1:16 PM, Nurse Practitioner #2 was interviewed and stated that they know gastrostomy tubes must be flushed with water before and after medications and that orders are written for flushes to be done daily. They stated there is no specific order for flushes to be done in between medications but that it is protocol. 10 New York Code Rules and Regulations 415.11 (c)(3)(i)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interviews, and record review, the facility failed to ensure that services provided meet professional standards of quality. This was evident for two (2) residents (Resident #7 and Resident #28) observed during Medication Administration. Specifically, 1). Registered Nurse #8 did not check for patency and placement of the Resident #7's gastrostomy tube (a surgically placed tube that delivers nutrition, fluids, and medications directly into the stomach) prior to administering medications, and 2). Registered Nurse #9 checked for patency and placement of Resident #28's gastrostomy tube by auscultation (listening to sounds with a stethoscope) instead of using a recommended method for checking placement. The findings include: The standard of practice for maintaining the patency of intravenous catheters, as defined by the Infusion Therapy Standards of practice published by the Infusion Nurses Society in 2024, dictates the administration of antibiotics via the sequence of, saline-administer-heparin-saline, is a standardized flushing sequence designed to maintain vascular access patency, prevent occlusion, and ensure safe medication administration. The standard of practice for preparing and administering medications via enteral tube, as defined by the American Society of Parenteral and Enteral Nutrition, in conjunction with the Institute of Safe Medication Practices' publication in 2022, is that the tube must be manually flushed with at least 15 milliliters of purified water before and after each medication. Medications should not be mixed together in order to prevent drug-drug interactions which can interfere with the intended therapeutic response or form precipitates that may clog the feeding tube. The facility policy titled Intravenous Therapy, with an approval and implementation date of 11/2008, stated that the licensed nurse will observe all resident's safety and infection control principles in intravenous insertion and administration of intravenous infusion and medications. The administration of intravenous medication procedure detailed in the policy did not provide documented guidance to flush the access line to ensure the line remains clear with proper catheter function for safe medication delivery and for reduced risk of infection. The facility policy titled Feeding Tubes Enteral - Nutrition and Medication, with an approval date of 09/29/2025, stated the facility will ensure that a resident who is fed by enteral feeding tube shall receive the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, significant regurgitation, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers, and to restore, if possible, normal feeding function. The Medications via Gastrostomy Tube: Guidelines for Administration, procedure detailed in the policy documented the administration procedure begins with thirty to fifty (30-50) milliliters of water flush. Then using a sufficient volume of fluid (which will depend on the individual medication), mix each medication with water, and pour into tube. Flush in between each medication with minimum ten to fifteen (10-15) milliliters of water. After last medication is administered, flush with thirty to fifty (30-50) milliliters of water. 1. Resident #7 was admitted to the facility with diagnoses including chronic lung disease (a progressive lung disease characterized persistent airflow limitation), respiratory failure (difficulty breathing), and atrial fibrillation (irregular heart rhythm). The doctor's order with start date 05/10/2026 instructs midline flush using SASH (Saline, Antibiotic, Saline, Heparin) before and after administration of medication until complete and to schedule frequency as per antibiotic order. The Physicians order with a start date of 04/26/2026 documented piperacillin-tazobactam (an antibiotic medication) 3.375 grams intravenous solution-infuse 3.375 grams by intravenous route every six (6) hours for six (6) weeks On 05/18/2026 at 11:30 AM, Registered Nurse #8 was observed preparing and administering the antibiotic medication for Resident #7. Registered Nurse #8 mixed and prepared the (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	medication and placed medication, two saline flushes, one heparin flush, one tubing set, and alcohol pads on a cleaned tray and proceeded to enter Resident #7's room. Registered Nurse #8 failed to flush the midline with saline prior to attaching the primed line of antibiotic. After administering the medication, Registered Nurse #7 threw away the supplies left on the tray and cleaned the tray without flushing with saline or heparin. On 05/18/2026 at 4:34 PM, Registered Nurse #8 was interviewed and stated that they performed the SASH (Saline, Antibiotic, Saline, Heparin) order in the morning to check the patency of the midline. Registered Nurse #8 also stated they forgot to flush the midline with saline prior to administering the intravenous antibiotic and they threw the supplies out without flushing the line after. On 05/19/2026 at 3:10 PM, Registered Nurse #11, the nursing supervisor, was interviewed and stated the SASH (Saline, Antibiotic, Saline, Heparin) order must be performed to ensure the patency of the midline, and it should be performed for each antibiotic administration. 2. Resident #28 was admitted to the facility with diagnoses including seizure disorder, malnutrition, and gastroesophageal reflux disease. On 05/19/2026 at 8:47 AM, Registered Nurse #7 was observed performing medication administration for Resident #28. Registered Nurse #7 prepared ten medications for administration, entered Resident #28's room and prepared to administer medication. Registered Nurse #7 stopped the tube feed and administered approximately fifteen (15) milliliters of water. Registered Nurse #7 then proceeded to administer each medication via gastrostomy tube one after the other and did not flush the tube with water after each medication. After all medications were administered, Registered Nurse #7 poured approximately fifty (50) milliliters of water into the tube, then an additional forty (40) milliliters before restarting the tube feeding. On 05/19/2026 at 10:09 AM, Registered Nurse #7 was interviewed and stated that usually the gastrostomy tube would be flushed with water, then medications would be administered one by one, and finally the tube would be flushed with water at the end. Registered Nurse #7 also stated that flushing between medications is done sometimes but they did not flush between medications for Resident #28 because the resident was receiving a lot of medications. On 05/19/2026 at 12:19 PM, Registered Nurse #10, who is the nursing supervisor, was interviewed and stated when administering medications via gastrostomy tube, first the tube would be flushed with at least thirty (30) milliliters of water, the medications may be administered, and then the tube would be flushed again with at least thirty to fifty (30-50) milliliters of water. Registered Nurse #10 also stated that water should be flushed between medications to ensure that there is no residual medication is in the tube. Registered Nurse #10 further stated that the facility's policy states that water flushes should be performed between medications. On 05/20/2026 at 10:30 AM, Registered Nurse #6 was interviewed and stated that water flushes between medications during medication administration does not require an order because it is part of the facility's protocol. On 05/20/2026 at 10:03 AM, the Director of Nursing was interviewed and stated the SASH (Saline, Antibiotic, Saline, Heparin) order must be performed for every antibiotic administered intravenously. The Director of Nursing also stated that for gastrostomy tube medication administration, thirty (30) milliliters of water should be used to initially flush the tube, then medications may be administered one at a time with water flushes in between. If there is noticeable medication left in administration cup, then more water should be used to dissolve the medication, and it should be administered, and this should be done to ensure that the full intended dose has been administered. The Director of Nursing further stated that after medications are given, the tube should be flushed again with water, and in-service for gastrostomy tube medication administration had recently been conducted for nursing staff about a month ago. On 05/20/2026 at 1:16 PM, Nurse Practitioner #2 was interviewed and stated that they know gastrostomy tubes must be flushed with water before and after medications and that orders are written for flushes to be done daily. Nurse (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Practitioner #2 also stated there is no specific order for flushes to be done in between medications but that it is protocol. 10 New York Code, Rules and Regulations 415.11 (c)(3)(i)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure that drugs and biologicals were stored in locked compartments. This was evident for one (1) unit (Unit 6) of eight (8) units observed for Medication Storage. Specifically, seven (7) blister packs of medications and a bag containing several vials of unmixed antibiotics for several residents were observed in an open box in an unlocked nursing supervisor's office which was located across from the nurse's station on Unit 6. The findings include: The facility policy titled Medication Storage Guidelines with an approval date of 03/10/2026 stated all drugs and biologicals are to be stored in a secure and orderly manner under proper temperatures and are to be accessible only to licensed nursing and pharmacy personnel. On 05/13/2026 at approximately 12:30 PM, the New York State Department of Health Life Safety Surveyor reported to the State Surveyor that they observed medications in a box in the Unit 6 nursing supervisor's office. On 05/13/2026 at 12:53 PM, Registered Nurse #5, who is the supervisor, was observed exiting the Unit 6 nursing supervisor's office and then returned to the office at 12:55 PM. The office was left unlocked, there was no staff present, and medications were left unattended, not supervised by staff. During this period staff had passed by the nurse's station area intermittently. On 05/13/2026 at 1:24 PM, Registered Nurse #4 was observed in the Unit nursing supervisor's office. There were several blister packs of medications for Residents #26, #59, and #253 including Omeprazole, Famotidine, Icosapent, Escitalopram, and Amlodipine and a bag with several vials of unmixed antibiotics for Resident #47 consisting of [NAME]/Tazobactam (Zosyn) in a cardboard box in the corner of the office. Registered Nurse #4 was interviewed immediately and stated these medications were supposed to be brought down to the nursing supervisors office on the main level to be returned to the pharmacy. Registered Nurse #4 also stated the Unit 6 nursing supervisor's office door is kept unlocked throughout their shift because nurses come and go. On 05/13/2026 at 1:29 PM, Registered Nurse #4 was observed exiting the Unit 6 nursing supervisor's office and then returned to the office at 1:33 PM. The office was left unlocked, with no staff present, and medications were left unattended, not supervised by staff. During this period had staff passed by the nurse's station area intermittently. On 05/15/2026 at approximately 12:40 PM, Registered Nurse #5 was interviewed and stated the nurses had collected all discontinued and expired medications on the unit and placed them in the Unit 6 nursing supervisor's office to be brought down by the night shift to the nursing office on the main floor. Registered Nurse #5 also stated the Unit 6 nursing supervisor's office door is always locked, and the Certified Nursing Assistants keep their personal belongings in there as well. Registered Nurse #5 was unable to explain why the State Surveyor observed the office door unlocked on more than one occasion with medications unattended inside. On 05/20/2026 at 12:51 PM, the Director of Nursing was interviewed and stated the nurses are instructed to bag the discontinued and expired medications and then bring them downstairs to the nursing office so they can be returned to the pharmacy. The Director of Nursing also stated medications are not supposed to be kept in the unit nursing supervisor's office. The Director of Nursing further stated if there was an emergency and they had to place the medications in the unit nursing supervisor's office, then they should lock the door. 10 New York Codes, Rules and Regulations 415.18(e) (1-4)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interviews, and record review, the facility failed to maintain medical records that are accurately documented. This was evident for one (1) out of three (3) residents (Resident #28) reviewed for Tube Feeding out of a total of 38 sampled residents. Specifically, Resident #28's medication orders inaccurately documented to be given by oral route when medications were being given by gastrostomy tube (a flexible tube placed in the stomach for feeding, hydration and medication administration). The findings include: The facility policy titled Physicians Orders, with an implementation date of 05/07/2012 and approval date of 04/05/2026 stated that the facility will ensure that physician orders are timely and accurately carried out. The policy also stated the physician should provide clear medication orders to avoid misinterpretation and potential medication errors. The facility further stated that it is the physician's responsibility to review, enter and approve orders into the electronic medical record and that the nurse's responsibility is to pick up the order which transcribes the order into the medication and/or treatment administration record. Resident #28 was admitted to the facility with diagnoses including hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormone), and seizure disorder (unprovoked seizures caused by abnormal brain activity), and malnutrition (imbalance of nutrients the body needs and obtains). A physician's order dated 04/07/2026 documented Levothyroxine 150 microgram tablet, give one tablet by oral route every day. A physician's order dated 05/05/2026 documented Keppra 100 milligram per milliliter oral solution, give one (1) milliliter by oral route three times a day. On 05/19/2026 at 8:55 AM, Registered Nurse #7 was observed preparing and administering medications for Resident #28. Levothyroxine 150 microgram tablet was crushed and administered via gastrostomy tube. On 5/19/2026 at 11:04 AM, Registered Nurse #7 was interviewed and stated that the medication administration process included identifying the patient and ensuring the medication order is for the right patient, right medication, right dose, right time, and right route. Upon review of physician orders, Registered Nurse #7 stated that they did not notice the route documented for medication orders of levothyroxine tablets and Keppra oral solution was documented to be oral instead of gastrostomy tube. Registered Nurse #7 further stated that they have been giving all medications for Resident #28 via gastrostomy tube. Registered Nurse #7 stated that it is the nurse's responsibility to update the nursing supervisor, or the medical provider that the medication was ordered incorrectly. On 05/19/2026 at 12:19 PM, Registered Nurse #11, who is the nursing supervisor, was interviewed and stated that it is the nurses' and the nursing supervisor's responsibility to note and update medication orders if the route is incorrect. Registered Nurse #11 also stated that at times the medical provider may not realize that the route of administration was entered incorrectly. On 05/20/2026 at 1:16 PM, Nurse Practitioner #2 was interviewed and stated that nursing supervisors place orders, and the nurse practitioners and doctors review orders and sign them. Nurse Practitioner #2 also stated that the nurses or nursing supervisors can let the medical providers know when a change in the order needs to be made. Nurse Practitioner #2 further stated that since Resident #28 did not have a gastrostomy tube on a previous admission to the facility, it is possible that the provider who put in the order and/or signed the order did not remember that the gastrostomy tube was in place and ordered medications via oral route. On 05/20/2026 at 10:03 AM, the Director of Nursing was interviewed and stated that when administering medications, the first step is to check the medication order and ensure that it is for the right patient, the right medication, the right dose, the right route and the right time. The Director of Nursing also stated that nurses and nursing supervisors can identify (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that a medication order was written for the wrong route and can make the provider aware that it needs to be changed. 10 New York Codes, Rules and Regulations 415.3.(e)(1)		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, and record review, the facility failed to 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. This was evident for one (1) resident observed during Medication Administration. Specifically, Registered Nurse #8 was observed changing gloves multiple times during medication administration without performing hand hygiene between glove changes. The findings include: The facility policy titled Hand Hygiene, effective 12/07/2021 and last revised 03/05/2026, stated that all members of the healthcare team will comply with current Centers for Disease Control and Prevention hand hygiene guidelines as effective hand hygiene reduces the incidence of healthcare associated infections. The indications for handwashing and hand rubbing listed in the policy both include after glove removal as a clinical situation where hand hygiene is appropriate. The policy also stated that the use of gloves does not eliminate the need for hand hygiene and hands should be decontaminated after removing gloves. The policy further stated that during medication preparation and administration, after gloves are removed, hand hygiene is to be performed before moving on to the next task or resident. 1. Resident #7 was admitted to the facility with diagnoses including chronic lung disease (a progressive lung disease characterized persistent airflow limitation), respiratory failure (difficulty breathing), and atrial fibrillation (irregular heart rhythm). On 05/18/2026 at 4:10 PM, Registered Nurse #8 was observed administering three medications via gastrostomy tube (a tube inserted into the stomach to provide direct access for feeding, hydration or medication administration) for Resident #7. Registered Nurse #8 was observed performing three (3) glove changes during the medication administration and did not perform hand hygiene between any glove change. On 05/18/2026 at 4:34 PM, Registered Nurse #8 was interviewed and stated that hand hygiene should be performed between glove changes. Registered Nurse #8 also stated they were rushing and were nervous during medication administration observation and so forgot to perform hand hygiene. The document titled Hand-Washing Competency for Registered Nurse #8 dated 06/06/2026 documented the observation was satisfactory. On 05/19/2026 at 3:15 PM, Registered Nurse #11, who is the nursing supervisor, was interviewed and stated that hand hygiene should be performed before entering and after exiting the resident's room, before medication preparation and administration, and before and after gloves are worn. On 05/20/2026 at 10:03 AM, the Director of Nursing was interviewed and stated that hand hygiene should be performed prior to entering a resident's room, prior to preparing medications, and between glove changes. The Director of Nursing also stated that if handwashing cannot be performed, alcohol-based hand sanitizer is available on every medication cart. On 05/20/2026 at 1:10 PM, Registered Nurse #3, who is also the Infection Preventionist, was interviewed and stated that hands must be washed prior to medication preparation and that after about five uses of hand sanitizer. Registered Nurse #3 also stated that after gloves are removed, hand hygiene must be performed before a new set of gloves can be put on. 10 New York Code Rules and Regulations 415.19 (b)(4)		