STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335817	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Care Center	135 Franklin Avenue Franklin Square, NY 11010

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on record review and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 8/30/2024, the facility did not ensure that a Pre-Admission Screening and Resident Review (PASARR) was completed for each resident prior to their admission to the facility to determine that the individual requires the level of services provided by the nursing facility and whether the individual requires specialized services. This was identified for one (Resident #29) of 26 residents reviewed for Pre-Admission Screening and Resident Review (PASARR). Specifically, Resident #29 was admitted to the facility in October 2023. There was no documented evidence that a Level 1 Pre-Admission Screening and Resident Review (PASARR) was completed prior to Resident #29's admission. The finding is: The facility's policy and procedure titled Pre-Admission Screening and Resident Review (PASSR) last revised on 6/26/2024 documented that the admission coordinator will ensure a screen is completed before admission for all new admissions. Resident #29 was admitted to the facility on [DATE] with diagnoses of Major Depressive Disorder, Diabetes Mellitus, and Myalgia (muscle pain). The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderately impaired cognition. The assessment's Pre-Admission Screening and Resident Review (PASARR) section documented that Resident #29 was not currently considered by the State level II Pre-admission Screening and Resident Review (PASARR) process to have a serious mental illness, intellectual disability, or other related conditions. The facility failed to provide documented evidence that a Pre-Admission Screening and Resident Review (PASARR) form was completed and reviewed prior to Resident #29's admission. The Director of Admissions was interviewed on 8/29/2024 at 11:15 AM and stated they were not employed at the facility in October 2023. The Director of Admissions stated that the admission department is responsible for reviewing and ensuring that the resident's admission documents from the sending facility include a Pre-Admission Screening and Resident Review (PASARR) form. The Director of Admissions stated that if a screen form was not included or was incomplete, they would reach out to the case worker from the sending facility to obtain a completed copy of the screen form. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Social Work was interviewed on 8/29/2024 at 11:32 AM and stated that Resident #29's Pre-Admission Screening and Resident Review (PASARR) form was not found. The Director of Social Work stated that the admission staff who admitted Resident #29 should have ensured that a Pre-Admission Screening and Resident Review (PASARR) form was completed for Resident #29 by the sending facility, prior to their admission. The Director of Social Work stated that the Pre-Admission Screening and Resident Review (PASARR) form was also reviewed by the Social Worker prior to the resident's admission because if a Level II referral was recommended, the Social Work Department is responsible for obtaining recommended services such as psychiatric evaluation assessment and ensuring that the facility can provide the services. The Administrator was interviewed on 8/29/2024 at 2:42 PM and stated that Resident #29's Pre-Admission Screening and Resident Review (PASARR) form was not found and they were not able to obtain the copy from the sending facility. The Administrator stated that the admission department is expected to review and ensure that each resident has a completed Pre-Admission Screening and Resident Review prior to their admission to the facility. The Administrator stated that the Pre-Admission Screening and Resident Review (PASARR) form is essential to determine whether the facility can offer a safe placement and provide appropriate services to the resident. 10 NYCRR 415.11(e)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on record review and interviews conducted during a Recertification Survey initiated on 8/26/2024 and completed on 8/30/2024, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice. This was identified for one (Resident #1) of five residents reviewed for Unnecessary Medications. Specifically, Resident #1 with a diagnosis of Diabetes Mellitus had a physician's order to monitor the resident's blood glucose level as per the facility's protocol. The facility policy indicated reporting the findings to the Physician if the blood glucose levels were less than 100 milligrams/Deciliter or greater than 300 milligrams /Deciliter. Resident #1's blood glucose levels were less than 100 milligrams/Deciliter or greater than 300 milligrams /Deciliter on 27 occasions in July 2024 and on 13 occasions in August 2024 and the resident's Physician was not notified as per the facility protocol. Additionally, the insulin injection sites were not documented in the resident's medical record on 50 occasions in July 2024 and 70 occasions in August 2024. The finding is: The facility's policy titled Fingerstick Blood Glucose Level Monitoring, last revised May 2024, documented that glucose and fingerstick results with blood sugar levels of less than 100 milligrams/Deciliter or greater than 300 milligrams/Deciliter will be reported to the Primary Care Physician/Nurse Practitioner. The facility's policy titled Medication Administration, last revised May 2024, documented that when giving insulin, site rotation should be charted in the Medication Administration Record. Resident #1 was admitted with diagnoses of Diabetes Mellitus with Diabetic Polyneuropathy (nerve involvement), Hypertension, and Peripheral Autonomic Neuropathy. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The Minimum Data Set documented Resident #1 received insulin injections. The physician's order dated 7/5/2024 documented to administer 4 units of Novolog 100 unit/milliliter insulin subcutaneously three times a day and to monitor blood sugar levels as per protocol. The physician's order dated 7/5/2024 documented to administer 18 units of Lantus Solostar 100 unit/ milliliter subcutaneously once daily at bedtime and to monitor blood sugar levels as per protocol. The Comprehensive Care Plan (CCP) for Diabetes Mellitus dated 7/8/2024 documented interventions to administer antidiabetic medication as ordered, to monitor blood glucose/fingerstick levels as ordered, and to monitor for signs and symptoms of Hypoglycemia (low blood glucose) or Hyperglycemia (high blood glucose). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The July 2024 Medication Administration Record documented the resident's blood sugar levels greater than 300 milligrams /Deciliter on 7/9/2024 at 5:03 PM; 7/13/2024 at 5:00 PM; 7/16/2024 at 8:28 AM and 12:07 PM; 7/17/2024 at 9:38 AM; 7/18/2024 at 10:00 PM; 7/19/2024 at 5:07 AM; 7/20/2024 at 12:41 PM; 7/21/2024 at 4:37 PM and 9:10 PM; 7/22/2024 at 8:36 AM, 12:40 PM, and 5:16 PM; 7/23/2024 at 5:11 PM and 9:45 PM, 12:33 PM, 4:33 PM and 8:59 PM; 7/25/2024 at 7:30 AM and 5:00 PM; 7/26/2024 at 11:30 AM; 7/27/2024 at 5:04 PM; 7/28/2024 at 12:18 PM and 5:03 PM; 7/29/2024 at 5:04 PM and 8:55 PM; and on 7/31/2024 at 9:09 PM. There was no documentation in the medical record that the resident's Physician was notified of the elevated blood glucose levels as per the facility's protocols. The July 2024 Medication Administration Record review also revealed that the insulin injection administration site was not documented for 50 out of 100 occasions. The August 2024 Medication Administration Record documented the blood sugar levels were either less than 100 milligrams /Deciliter or greater than 300 milligrams /Deciliter on 8/3/2024 at 7:30 AM, 11:30 AM, and 8:39 PM; 8/4/2024 at 12:35 PM, 5:00 PM, and 8:34 PM; 8/5/2024 at 12:57 PM; 8/6/2024 at 9:31 AM; 8/16/2024 at 11:30 AM; 8/19/2024 at 12:50 PM; 8/24/2024 at 9:51 AM; 8/25/2024 at 9:24 AM; 8/26/2024 at 9:45 PM. There was no documentation in the medical record that the resident's Physician was notified of these blood glucose levels. The August 2024 Medication Administration Record review also revealed that the insulin injection administration site was not documented for 68 out of 106 occasions. Licensed Practical Nurse #2 was interviewed on 8/28/2024 at 2:02 PM and stated they were the regularly assigned medication nurse on Resident #1's unit during the 7:00 AM- 3:00 PM shift. Licensed Practical Nurse #2 stated they were familiar with Resident #1 and would consider the resident's blood sugar level out of range if the blood glucose level was below 70 milligrams /Deciliter and greater than 255 milligrams /Deciliter. Licensed Practical Nurse #2 stated they would notify the unit manager if the resident's blood sugar level was out of range. Licensed Practical Nurse #2 stated Resident #1's physician's orders did not include the blood glucose parameters to indicate when a Physician should be notified and they did not know the facility protocol. Licensed Practical Nurse #2 stated that the insulin injection site should be rotated and documented to prevent insulin from being administered repeatedly at the same location. Licensed Practical Nurse #2 stated that repeated injection administration at the same site may potentially cause swelling and bruising to the area. Licensed Practical Nurse #2 did not know why they did not document the insulin injection sites after they administered the insulin to the resident. Registered Nurse #5, the unit manager, was interviewed on 8/28/2024 at 2:32 PM and stated nurses should notify their supervisor each time when a resident's blood sugar level is below 100 milligrams /Deciliter and greater than 300 milligrams /Deciliter as per the facility's protocol. Registered Nurse #5 stated they were never notified of Resident #1's unstable blood sugar results and thought the resident's blood sugar was under control. Registered Nurse #5 stated nurses should document the injection site after each insulin administration and the site should be rotated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #3 was interviewed on 8/28/2024 at 3:31 PM and stated they were the regularly assigned 3:00 PM-11:00 PM medication nurse. Licensed Practical Nurse #3 stated when Resident #1's blood sugar level exceeded 300 milligrams /Deciliter, they did not inform the Physician because Resident #1's physician's order did not have parameters. Licensed Practical Nurse #3 stated they were not aware of the facility protocol regarding when to report the blood glucose levels to a medical provider. Physician #3 was interviewed on 8/30/2024 at 11:04 AM and stated they expected the nursing staff to follow the facility protocol and notify the Physician when the blood glucose levels are outside the established parameters so they can monitor the effectiveness of the resident's current diabetes management and re-adjust the resident's medication dose as necessary. The Director of Nursing Services was interviewed on 8/30/2024 at 11:23 AM and stated nursing staff should follow the facility protocol and notify the Physician each time the resident's blood sugar is below 100 milligrams /Deciliter or higher than 300 milligrams /Deciliter unless otherwise specified by the Physician. The Director of Nursing Services stated insulin injection site should be rotated and nurses should document the injection site each time insulin was administered. The Director of Nursing Services stated that repeated injections at the same site can cause swelling and redness and affect the absorption of insulin. 10NYCRR 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 8/30/2024 the facility did not ensure that each resident with Pressure Ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for three (Resident #38, Resident #5, and Resident #82) of eight residents reviewed for Pressure Ulcers. Specifically, 1) Resident #38 had multiple pressure ulcers and had a physician's order to use a low-air loss mattress for pressure relief. During multiple observations, the adjustable weight setting for the air mattress, which is meant to correspond to the resident's weight, was not set accurately. 2) Resident #5 had a history of Moisture Associated Skin Damage to the left buttock. Resident #5 had an order for a low-air loss mattress. During multiple observations, the adjustable weight setting for the air mattress was not set accurately. 3) Resident # 82 had Moisture Associated Skin Damage to the sacrum area. Resident #82 had an order for a low-air loss mattress. During several observations, the adjustable weight setting for the air mattress was not set accurately. The findings are: The facility's policy titled Pressure Injury Management and Prevention revised on 5/2024, documented it is the policy of the facility to have in place all necessary interventions to prevent the development of pressure ulcers and to facilitate healing of any existing pressure ulcers acquired before admission, readmission, or hospital return. Residents at risk for pressure injuries will have a preventative plan implemented and specific preventative care interventions may include pressure-relieving mattresses. The facility's policy titled Air Mattress revised on 1/01/2024 documented that air mattresses should be used as a tool to help with alleviating pressure. The use of an air mattress is an adjunct to proper turning and positioning with other pressure-relieving devices or interventions. The air mattress should be checked daily for proper functioning by staff and any issues will be reported to the unit nurse. The nursing staff will then set up the mattress according to the manufacturer's instructions. The operation manual for the low-air mattress documented instructions that included adjusting the internal pressure of the air mattress according to the patient's weight by using the weight button on the control panel of the power unit. 1) Resident # 38 was admitted with diagnoses including Dementia, Type 2 Diabetes Mellitus, and Pneumonia. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 99, which indicated the resident had severely impaired cognition. The Minimum Data Set documented the resident had three Stage 4 Pressure Ulcers. A Comprehensive Care Plan titled Pressure Ulcer/Injury was initiated on 4/05/2024 with documented interventions that included the use of a pressure relief mattress, turning and positioning the resident every 2 hours and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Wound Care Physician consultation dated 8/20/2024 documented the resident had a left foot arterial wound measuring 2.5 centimeters in length, 0.8 centimeters in width, and 0.1 centimeters in depth. A left Ischium/buttock Stage 4 Pressure Ulcer (full thickness with an exposed underlying structure) measuring 3.5 centimeters in length, 4.5 centimeters in width, and 2.7 centimeters in depth. A right Ischium/buttock Stage 4 Pressure Ulcer (full thickness with exposed underlying structure) measuring 4.2 centimeters in length, 1.8 centimeters in width, and 2.4 centimeters in depth, with undermining (when the edges of a wound separate from the surrounding tissue creating a pocket underneath the wound surface) measuring 3.1 centimeters. A sacrum Stage 4 Pressure Ulcer (full thickness with exposed underlying structure) measuring 7 centimeters in length, 6.2 centimeters in width, 2.4 centimeters in depth, with undermining measuring 2.4 centimeters. A physician's order dated 7/08/2024 and last renewed on 8/09/2024 documented the use of a low-air loss mattress. A review of the electronic medical record indicated Resident #38's most recent weight was 85 pounds on 8/29/2024. Resident #38 was observed in bed on 8/26/2024 at 10:03 AM. The air mattress weight setting was set at 325 pounds. Resident #38 was observed in bed on 8/26/2024 at 12:19 PM, the air mattress weight setting was set at 325 pounds. Resident #38 was observed in bed on 08/27/24 at 08:50 AM. The air mattress weight setting was set at 325 pounds. Nurse Supervisor #2 was interviewed on 8/28/2024 at 9:16 AM and stated Resident #38 has multiple skin breakdowns and uses the air mattress. The air mattress weight setting should be adjusted to the resident's weight. Nurse Supervisor #2 stated the resident's air mattress weight setting was set at 325 pounds and the resident weighs 85 pounds. The wound care nurse is responsible for ensuring that the air mattress weight setting is accurately set. Nurse Supervisor #2 stated they were only responsible for ensuring that the air mattress was not deflated and was functioning properly. Wound Care Nurse #3 was interviewed on 8/28/2024 at 10:44 AM and stated they check all the air mattresses daily to ensure that the weight setting is set according to the residents' weight. Wound Care Nurse #3 stated Resident #38 weighs 85 pounds, and the air mattress weight setting should not be set at 325 pounds. Certified Nursing Assistant #1 was interviewed on 8/29/2024 at 10:00 AM and stated they are the regularly assigned 7:00 AM-3:00 PM shift Certified Nursing Assistant for Resident #38. Certified Nursing Assistant #1 stated they do not touch the setting on the air mattress and if they identify any concerns with the air mattress, they report them to the unit nurse. Wound Care Physician #2 was interviewed on 8/29/2024 at 11:19 AM and stated the purpose of the air mattress is to relieve pressure from wounds and to prevent further pressure ulcer development. The mattress weight setting should be set according to the resident's weight and the manufacturer's guidelines. If the weight setting for the air mattress is too high or too low, it can cause more pressure injury and impede the healing of the current wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing Services was interviewed on 8/29/2024 at 11:27 AM and stated the air mattress weight setting should be set according to the resident's weight. The nurses are responsible for monitoring the air mattress weight setting when the wound nurse is not in the building. 2) Resident #5 was admitted with diagnoses that included Heart Failure, Major Depressive Disorder, and Dementia. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 99, which indicated the resident had severely impaired cognition. The Minimum Data Set documented that Resident #5 had Moisture Associated Skin Damage. A Comprehensive Care Plan titled Pressure Ulcer/Injury was initiated on 5/12/2023 and last revised on 8/08/2024 documented interventions that included the use of a pressure relief air mattress and encouraging the resident to turn in bed. A physician's order dated 3/18/2024 and renewed on 8/03/2024 documented the use of a low-air loss mattress. A Wound Care Physician's consultation dated 8/20/2024 documented Resident #5 had Moisture Associated Skin Damage to the left buttock that was now healed. A review of the electronic medical record indicated Resident #5's most recent weight was 173 pounds on 8/03/2024. Resident #5 was observed in bed on 8/26/2024 at 9:45 AM. The air mattress weight setting was set at 250 pounds. Resident #5 was observed in bed eating their breakfast on 8/27/2024 at 8:48 AM. The air mattress weight setting was set at 250 pounds. Resident #5 was observed in bed on 8/28/2024 at 9:22 AM. The air mattress weight setting was set at 250 pounds. Nurse Supervisor #2 was interviewed on 8/28/2024 at 09:22 AM and stated Resident #5's air mattress weight setting was set at 250 pounds and currently the resident weighs 173 pounds. The air mattress weight setting should be set according to the resident's weight. The Director of Nursing Services was interviewed on 8/29/2024 at 11:27 AM and stated the air mattress weight setting should be set according to the resident's weight. The nurses are responsible for monitoring the air mattress weight setting when the wound nurse is not in the building. 34798 3) Resident #82 was admitted with diagnoses including Diabetes Mellitus, Non-Alzheimer's Dementia, and Muscle Wasting and Atrophy. The 6/30/2024 Significant Change Minimum Data Set assessment did not have a Brief Interview for Mental Status score due to the resident's severely impaired cognitive skills for daily decision-making. The Minimum Data Set assessment documented the resident was at risk for pressure ulcer development. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Comprehensive Care Plan titled Pressure Ulcer/Skin Integrity Alteration Risk, effective 10/4/2023 and last updated on 7/8/2024, documented an intervention for a low air loss mattress. An update on 7/3/2024 documented that the resident was on comfort care and was at increased risk of skin breakdown. A physician's order dated 10/3/2023 and last updated 8/26/2024 documented the use of a Low Air Loss Mattress. A physician's order dated 4/12/2024 and last updated 8/26/2024 documented under Advanced Directives: Comfort Measures Only. A physician's order dated 8/5/2024 and last updated 8/26/2024 documented cleanse sacral area with soap and water, pat dry, apply zinc oxide (topical wound treatment) and cover with dressing every shift for diagnosis of irritant contact dermatitis due to friction or contact with body fluids. A wound care weekly note dated 8/21/2024 written by Registered Nurse #3 (wound care nurse) documented: sacrum-moisture associated skin damage measuring 5 centimeters in length and 4 centimeters in width; interventions included to apply zinc oxide treatment and offloading with low air loss mattress. Resident #82's weight in the medical record as of 8/2/2024 was 122 pounds. On 8/26/2024 at 9:38 AM Resident #82 was observed in bed. The air mattress weight setting was set at 250 pounds. On 8/28/2024 at 9:08 AM Resident #82 was observed in their wheelchair in their room. The air mattress weight setting was set at 250 pounds. On 8/28/2024 at 9:21 AM Registered Nurse #2 (unit supervisor) observed Resident #82's mattress and confirmed the weight was set at 250 pounds. Registered Nurse #2 checked the resident's weight in the medical record and stated the last recorded weight was 122 pounds. Registered Nurse #2 stated the wound care nurse does daily rounds and is supposed to check the air mattress weight setting and the mattress weight setting is supposed to be set according to the resident's weight. Registered Nurse #2 stated our job as nurses on the unit is to make sure the mattress is not deflated and ensure that the air mattress is functioning properly. It is the wound care nurse's job to ensure the setting is consistent with the resident's weight. Registered Nurse #2 stated they do not check the air mattress weight setting because it has been set by the wound care nurse. Registered Nurse #4, the Clinical Supervisor, was interviewed on 8/28/2024 at 10:31 AM. Registered Nurse #4 stated the wound care nurse orders the air mattress and sets the weight setting on the air mattress based on the resident's weight. Any unit nurse can let the wound care nurse know if the weight setting is not accurate. The unit nurses do environmental checks, so checking the mattress weight setting should be a part of the environmental checks. Registered Nurse #3, the wound care nurse, was interviewed on 8/28/2024 at 10:45 AM. Registered Nurse #3 stated the weight setting on the air mattress should be consistent with the resident's weight and they check the air mattress weight setting on daily rounds, but they have not been in the building for several days. Registered Nurse #3 stated they did not know that there was no protocol for the unit nurses to check the air mattress weight setting in their absence. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician #2, the wound care consultant, was interviewed on 8/29/2024 at 11:19 AM and stated residents with pressure ulcers should have an air mattress in place to prevent further pressure ulcer development. The purpose of the air mattress is to relieve pressure from wounds and to prevent further pressure ulcers. The mattress should be set according to the resident's weight and the manufacturer's guidelines. If a mattress weight is set too high or too low, it can cause more pressure injury and impede healing of the current wounds. The Director of Nursing Services was interviewed on 8/29/2024 at 11:27 AM and stated the air mattress weight should be set consistent with the resident's weight. The Director of Nursing Services stated the nurses on the unit are responsible for monitoring the mattress when the wound care nurse is not in the building. The nurses are aware that they are responsible for monitoring the settings on the mattress. 10 NYCRR 415.12(c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49245 Based on observation, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 8/30/2024, the facility did not ensure that each resident's environment remained as free of accident hazards as possible. This was identified for one (Third Floor) of three units observed during the initial tour. Specifically, a full oxygen E-Cylinder tank (portable oxygen tank) was observed in the third-floor day room that was not secured in a rolling safety stand or a metal rack. The finding is: The facility's policy and procedure titled Oxygen Therapy last revised on 5/2024 documented that safety devices in valves or cylinders shall never be tampered with. Cylinders shall not be chained to portable or movable apparatus such as beds and tables. Even if they are considered empty, cylinders shall never be used as rollers, supports, or for any other purpose other than that for which they are intended by the supplier. Cylinders and containers shall not be dropped, dragged, or rolled. Cylinders shall not be supported by, and neither cylinder nor container shall be placed in proximity of, radiators, steam pipes, or heat ducts. The policy did not include guidance on how to store an oxygen tank in resident units. During an observation on 8/26/2024 at 10:21 AM, a free-standing, unsecured E-cylinder tank was observed in the third-floor unit day room during an activity. The E-cylinder tank gauge needle was at 2,000 PSI (pounds per square inch) indicating that the tank was full. A Recreation Aide was present in the day room during the observation. The Recreation Aide was interviewed on 8/26/2024 at 10:22 AM and stated they did not notice the free-standing E-cylinder tank in the day room. The Recreation Aide stated they would call the nurse if they noticed the E-cylinder tank. Registered Nurse #5, the Unit Supervisor, was interviewed on 8/26/2024 at 10:25 AM and stated they did not know there was a free-standing E-cylinder tank in the day room. Registered Nurse #5 stated the oxygen tank should not be left unsecured and must be placed in a rolling cart or a metal rack to secure the E-cylinder tank. The Director of Maintenance and Housekeeping was interviewed on 8/27/2024 at 2:47 PM and stated the nurses are responsible for the oxygen tanks that are stored on the unit. The Director of Maintenance and Housekeeping stated all oxygen tanks must be secured with a rolling cart or a metal rack. The Director of Maintenance and Housekeeping stated there should not be an unsecured, free-standing E-cylinder tank on the unit. The Director of Maintenance and Housekeeping stated If the tank falls and the tank regulator and valve come off the top of the tank, the tank itself can propel like a rocket. The Director of Maintenance and Housekeeping stated an unsecured E-cylinder tank is an accident hazard. (continued on next page)

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	335817	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Care Center	135 Franklin Avenue Franklin Square, NY 11010

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 8/30/2024 at 9:54 AM and stated the E-cylinder tank should always be secured using a rolling cart or a metal rack. The Director of Nursing Services further stated an unsecured E-cylinder tank is an accident hazard. 10 NYCRR 415.12(h)(1)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 8/30/2024, the facility did not ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice. This was identified for two (Resident #5 and Resident #82) of two residents reviewed for Respiratory Care. Specifically, 1) Resident #5 had a physician's order to continuously receive oxygen therapy at 2 liters per minute. The resident was observed receiving an inaccurate amount of oxygen therapy on 8/26/2024, 8/27/2024, and 8/28/2024. 2) Resident #82 had a physician's order to continuously receive oxygen therapy at 2 liters per minute. The resident was observed receiving an inaccurate amount of oxygen therapy on 8/26/2024, 8/27/2024, and 8/28/2024. The findings are: The facility's policy titled Oxygen Therapy revised on 5/2024 documented that oxygen therapy must be ordered by a Physician or Nurse Practitioner and the flow rate of oxygen is to be set at the prescribed liters per minute. 1) Resident #5 was admitted with diagnoses that included Congestive Heart Failure, Major Depressive Disorder, and Dementia. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 99, which indicated the resident had severely impaired cognition. The resident had lower extremity impairment and was dependent on two or more helpers for chair to bed transfer. The Minimum Data Set documented that Resident #5 used oxygen therapy during the look-back period. The Comprehensive Care Plan for Oxygen Therapy last reviewed on 8/08/2024 documented to provide treatments and medications as per Physician orders. A physician's order dated 3/27/2024 last renewed on 8/03/2024 documented to administer 2 liters of oxygen continuously via a nasal cannula. Resident #5 was observed in bed sleeping on 8/26/2024 at 9:45 AM. The resident was receiving oxygen via an oxygen concentrator. The oxygen flow rate was set at 4 liters per minute. Resident #5 was observed in their room in a Geri chair on 8/26/2024 at 12:22 PM. The resident was receiving oxygen via an oxygen concentrator. The oxygen flow rate was set at 4 liters per minute. Resident #5 was observed in bed having breakfast on 8/27/2024 at 8:49 AM. The resident was receiving oxygen via an oxygen concentrator. The oxygen flow rate was set at 4 liters per minute. Resident #5 was observed in bed on 8/28/2024 at 9:24 AM. Nurse Supervisor #2 was also present in the room. The resident was receiving oxygen via an oxygen concentrator. The oxygen flow rate was set at 4 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Supervisor #2 was interviewed on 8/28/2024 at 9:24 AM and stated the resident was supposed to receive continuous oxygen at 2 liters per minute; however, the oxygen flow rate was set at 4 liters per minute. Nurse Supervisor #2 stated only the nursing staff is responsible for changing the oxygen setting on the oxygen concentrator. Nurse Supervisor #2 stated Resident #5 was not able to reach the concentrator from their bed or the Geri chair to change the oxygen setting. The Director of Nursing Services was interviewed on 8/28/2024 at 12:56 PM and stated that the nurses on the unit should monitor the oxygen levels of each resident who is receiving oxygen during their shift. The nurses should regularly assess the resident's oxygen levels, and if an increase is needed, they should obtain an updated order from the Physician. 2) Resident #82 was admitted with diagnoses that included Dementia, Diabetes Mellitus, and Wheezing. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 99, which indicated the resident had severely impaired cognition. The Minimum Data Set documented Resident #82 used oxygen therapy during the look-back period. The Comprehensive Care Plan for Respiratory Care dated 4/01/2024 documented interventions including administering oxygen as per the physician's order. A physician's order dated 6/10/2024 and renewed on 8/26/2024 documented to administer 2 liters of oxygen continuously via a nasal cannula. Resident #82 was observed in bed on 8/26/2024 at 9:38 AM. The resident was receiving oxygen via an oxygen concentrator. The oxygen flow rate was set at 4 liters per minute. Resident #82 was observed in bed on 8/26/2024 at 12:21 PM. The resident was receiving oxygen via an oxygen concentrator. The oxygen flow rate was set at 4 liters per minute. Resident #82 was observed in bed on 8/27/2024 at 8:46 AM having breakfast. The resident was receiving oxygen via an oxygen concentrator. The oxygen flow rate was set at 4 liters per minute. Resident #82 was observed on 8/28/2024 at 9:29 AM in bed. Nurse Supervisor #2 was also present in the room. The resident was receiving oxygen via an oxygen concentrator. The oxygen flow rate was set at 5 liters per minute. Nurse Supervisor #2 was interviewed on 8/28/2024 at 9:29 AM and stated Resident #82 has a physician's order to administer oxygen at 2 liters per minute. Nurse Supervisor #2 acknowledged that the resident was receiving oxygen at 5 liters per minute. Nurse Supervisor #2 stated only the nurses are responsible for changing the oxygen setting on the oxygen concentrator. The nurses should be monitoring the oxygen level on each shift and if the resident needs an increase, they should increase oxygen and notify the Physician. Resident #5 was not able to reach the concentrator from their bed or the Geri chair to change the oxygen setting. The Director of Nursing Services was interviewed on 8/28/2024 at 12:56 PM and stated that the nurses on the unit should monitor the oxygen levels of each resident who is receiving oxygen during their shift. The nurses should regularly assess the resident's oxygen levels, and if an increase is needed, they should obtain an updated order from the Physician. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.12 (k)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observation, record review, and interviews during the Recertification Survey initiated on 8/26/2024 and completed on 8/30/2024 the facility did not ensure that it maintained an infection prevention and control program designed to help prevent the development and transmission of infectious diseases. This was identified for one (Resident #67) of three residents reviewed for tube feeding. Specifically, Resident #67 had a physician's order for Enhanced Barrier Precautions for the use of a gastrostomy tube (feeding tube inserted through the stomach for artificial feeding). During an observation, Registered Nurse Supervisor #2 was observed entering Resident #67's room without the use of Personal Protective Equipment (gown and gloves) and disconnected the tube feeding from the gastrostomy tube. The finding is: The facility policy titled Enhanced Barrier Precautions dated 5/06/2024 documented that Enhanced Barrier Precautions are indicated for residents with central lines, urinary catheters, feeding tubes, and tracheostomies. The Enhanced Barrier Precautions are employed when performing high-contact resident care activities such as device care or feeding tube use. Resident #67 was admitted with diagnoses including Type 2 Diabetes Mellitus, Cerebral Infarction (disrupted blood flow to the brain), and Dementia. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 8, indicating the resident had moderate cognitive impairment. The Minimum Data Set documented the resident utilized tube feeding. A physician's order dated 5/14/2024 and last renewed on 8/26/2024 documented Enhanced Barrier Precautions due to gastronomy tube. A Comprehensive Care Plan dated 5/14/2024 for Enhanced Barrier Precautions had interventions including the use of a gown and gloves when in contact with the gastronomy tube. Nurse Supervisor #2 was observed going into Resident #67's room on 8/26/2024 at 10:00 AM to respond to the tube feeding pump alarm. There was a sign at the door and above the resident's bed indicating the resident was on Enhanced Barrier Precautions. The sign read Everyone must clean hands before entering and leaving the room. Staff must wear gown and gloves for high-contact resident care. The sign had a list of device care including a feeding tube with directions to wear a gown and gloves when providing care. Nurse Supervisor #2 did not don (put on) a gown or gloves when they turned off the feeding pump and disconnected the tube feeding from the resident's gastronomy tube. Nurse Supervisor #2 was interviewed on 8/26/2024 at 10:05 AM and stated Resident #67 is on Enhanced Barrier Precautions for the use of a gastronomy tube. The staff needs to wear Personal Protective Equipment when coming in contact with the gastronomy tube. Nurse Supervisor #2 further stated they should have put on Personal Protective Equipment to disconnect the tube feed; however, they were nervous and wanted to promptly respond to the alarm. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Assistant Director of Nursing Services, the Infection Preventionist, was interviewed on 8/28/2024 at 1:45 PM and stated nursing staff are expected to use gowns and gloves when providing care to a resident with a feeding tube. A resident with a feeding tube is placed on Enhanced Barrier Precautions because the feeding tube can harbor organisms that can transfer to staff and then to other residents. Nurse Supervisor #2 should have put on a gown and gloves when they disconnected the tubing from the resident's gastronomy tube. The Director of Nursing Services was interviewed on 8/30/2024 at 9:52 AM and stated nursing staff should wear Personal Protective Equipment while caring for residents who are on Enhanced Barrier Precautions. 10 NYCRR 415.19 (a)(1-3)