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	03/04/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review, and interviews, the facility did not ensure that there was sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified on three (3) (Unit 1, Unit 2 and Unit 3) of three (3) resident units reviewed for the Sufficient Nursing Staffing Task. Specifically, the facility triggered for the low weekend staffing metric on the Centers for Medicare and Medicaid Services Payroll-Based Journal Staffing Data Report for Quarter two, Quarter three, and Quarter four of Fiscal Year 2025. A random sampling of facility nursing staffing assignments did not reflect the staffing numbers as stipulated in the Facility Assessment for Certified Nursing Assistants, Licensed Practical Nurses, and Registered Nurses. The finding is:The Centers for Medicare and Medicaid Services Payroll-Based Journal Staffing Data Report for Fiscal Year 2025, Quarter two (2) (January 1st-March 31), Quarter three (03) (April 1st-June 30th) and Quarter four (04) (July 1st - September 30th) indicated that the facility triggered for the Metric of Low Weekend Staffing based on the facility's submitted staffing data.The Facility Assessment last reviewed on 01/28/2026 documented that the facility has an average daily census of 143 residents and a bed capacity of 150. The Facility Assessment included an average census of 28 for Unit one (01), 59 for Unit two (02) and 56 for Unit three (03). The Facility Assessment documented that the facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for the residents competently during both day-to-day operations and emergencies.The following staffing plan was determined for Unit one (01):-During the Day shift (7:00 AM-3:00 PM), Unit one (01) required one (01) Registered Nurse, one (01) Licensed Practical Nurse, and four (04) Certified Nursing Assistants.-During the Evening shift (3:00 PM-11:00 PM), Unit one (01) required two (02) Registered Nurses, one (01) Licensed Practical Nurse, and four (04) Certified Nursing Assistants.-During the Day shift (7:00 AM-3:00 PM), Unit two (02) required one (01) Registered Nurse, two (02) Licensed Practical Nurses, and seven (07) Certified Nursing Assistants.-During the Evening shift (3:00 PM-11:00 PM), Unit two (02) required two (02) Registered Nurses, two (02) Licensed Practical Nurses, and seven (07) Certified Nursing Assistants.-During the Day shift (7:00 AM-3:00 PM), Unit three (03) required (01) Registered Nurse, two (02) Licensed Practical Nurses, and seven (07) Certified Nursing Assistants.-During the Evening shift (3:00 PM-11:00 PM), Unit three (03) required two (02) Registered Nurses, two (02) Licensed Practical Nurses, and seven (07) Certified Nursing Assistants.A review of the 7:00 AM-3:00 PM shift staffing schedule for Unit one (01) with a bed capacity of 30, indicated the following:-There were only three (03) Certified Nursing Assistants assigned for an average census of 26 residents on 01/04/2025, 03/02/2025, 03/16/2025, 04/13/2025, 05/18/2025, 05/25/2025, 08/17/2025, and 09/14/2025.A review of the 3:00 PM-11:00 PM shift staffing schedule for Unit one (01) indicated the following:-There was one (01) Registered Nurse assigned for an average census of 26 residents on 01/04/2025, 01/19/2025, 01/26/2025, 02/01/2025, 03/30/2025, 04/05/2025, 04/26/2025, 05/11/2025, 05/17/2025, 05/18/2025, 05/25/2025, 06/8/2025, 07/06/2025, 07/19/2025, 08/31/2025, 09/13/2025, 09/14/2025, 09/20/2025, 09/21/2025, and 09/27/2025.-There were only (continued on next page)

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

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	three (03) Certified Nursing Assistants assigned for an average census of 26 residents on 02/01/2025, 03/30/2025, 08/16/2025, 09/13/2025, and 09/21/2025.-There were only two (2) Certified Nursing Assistants assigned to an average census of 26 residents on 05/18/2025 and 08/17/2025.A review of the 7:00 AM-3:00 PM shift staffing schedule for Unit two (02), which had a bed capacity of 60, indicated the following:-There were four (04) Certified Nursing Assistants assigned to 57 residents on 03/30/2025.-There were five (05) Certified Nursing Assistants assigned to 55 residents on 04/13/2025, 05/11/2025, 08/24/2025, and 09/13/2025.-There were six (06) Certified Nursing Assistants assigned to an average of 56 residents on 01/04/2025, 04/26/2025, 05/17/2025, 05/25/2025, 06/08/2025, 06/22/2025, 07/06/2025, 07/27/2025, 08/10/2025, 08/16/2025, 08/23/2025, 08/31/2025, 09/14/2025, 09/21/2025, and 09/27/2025.A review of the 3:00 PM-11:00 PM shift staffing schedule for Unit two (02) indicated the following:-There was one (01) Registered Nurse assigned an average of 56 residents on 01/04/2025, 01/19/2025, 01/26/2025, 02/01/2025, 02/08/2025, 02/15/2025, 03/30/2025, 04/05/2025, 04/26/2025, 05/11/2025, 05/17/2025, 05/18/2025, 05/25/2025, 06/08/2025, 06/22/2025, 06/28/2025, 07/06/2025, 07/19/2025, 08/31/2025, 09/13/2025, 09/14/2025, 09/20/2025, 09/21/2025, and 09/27/2025.-There were six (06) Certified Nursing Assistants assigned to an average of 56 residents on 01/19/2025, 02/08/2025, 03/16/2025, 03/30/2025, 05/18/2025, 05/25/2025, 06/08/2025, 06/22/2025, 07/06/2025, 07/27/2025, 08/17/2025, 08/31/2025, and 09/14/2025.-There were five (05) Certified Nursing Assistants assigned to 53 residents on 09/13/2025.-There was one (01) Licensed Practical Nurse assigned to 59 residents on 07/27/2025.A review of the 7:00 AM-3:00 PM shift staffing schedule for Unit three (03), which had a bed capacity of 60, indicated the following:-There were four (04) Certified Nursing Assistants assigned to 54 residents on 01/04/2025. -There were five (05) Certified Nursing Assistants assigned to 56 residents on 09/27/2025.-There were six (06) Certified Nursing Assistants assigned to an average of 55 residents on 01/26/2025, 02/15/2025, 03/02/2025, 04/13/2025, 05/11/2025, 05/25/2025, 06/22/2025, 07/19/2025, 07/27/2025, 08/10/2025, 08/17/2025, 08/23/2025, 08/31/2025, 09/13/2025, 09/20/2025, and 09/21/2025.A review of the 3:00 PM-11:00 PM shift staffing schedule for Unit three (03) indicated the following:-There was one (01) Registered Nurse assigned an average of 54 residents on 01/04/2025, 01/19/2025, 01/26/2025, 02/01/2025, 02/08/2025, 03/30/2025, 04/05/2025, 04/26/2025, 05/11/2025, 05/17/2025, 05/18/2025, 06/08/2025, 06/22/2025, 06/28/2025, 07/06/2025, 07/19/2025, 08/31/2025, 09/13/2025, 09/14/2025, 09/20/2025, 09/21/2025, and 09/27/2025.-There was one (01) Licensed Practical Nurse was assigned to 52 residents on 01/19/2025.-There were five (05) Certified Nursing Assistants assigned to 56 residents on 09/13/2025.-There were six (06) Certified Nursing Assistants assigned to an average of 54 residents on 01/19/2025, 01/26/2025, 02/08/2025, 02/15/2025, 03/16/2025, 05/18/2025, 06/08/2025, 06/22/2025, 07/06/2025, 07/26/2025, 07/27/2025, 08/31/2025, 09/14/2025, and 09/27/2025. During an interview on 02/26/2026 at 11:14 AM, the Staffing Coordinator stated the facility had numerous unscheduled nursing staff absences in the last few quarters. The Staffing Coordinator stated that since the new Administrator started in June 2025, they hired new nursing staff specifically for the weekends. The new full-time nursing staff must cover weekends. The Staffing coordinator stated the facility uses agency staff for Certified Nursing Assistants and Nurses but is not successful in covering the call outs and staff absences. During an interview on 02/27/2026 at 2:39 PM, the Administrator stated that when they started in June 2025, they had identified that the facility had staffing challenges. The Administrator stated that the last few quarters had the same staffing plan for each unit on every shift. The Administrator stated they started to hold meetings with the staffing coordinator to monitor staffing closely, changed the scheduling application the facility was previously utilizing to track staff call outs. The changes made regarding the staffing improvement were not noticeable until after November 2025.During an interview on 03/02/2026 at 12:36 PM, the Director of Nursing Services stated that the facility had staffing challenges in the past few quarters, and they are currently working their improvement plan to address nursing staff shortage.10 NYCRR 415.13(a)(1)(i-iii)

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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. Based on observation and interviews, the facility did not ensure that all drugs and biologicals were stored in locked compartments. This was identified for one (1) of three (3) medication storage rooms observed during the Medication Storage task. Specifically, two medication cabinets, inside the central supply room, containing over the counter medication supply were left unlocked. The central supply room door lock was malfunctioning causing the door to remain unlocked.The finding is:The facility policy and procedure for Labeling and Storage of Drugs and Biologicals, last reviewed/revised on July 2025 documented that over-the-counter medications maintained in Central Supply shall be secured to prevent unauthorized access. The room shall remain locked when unattended. Access is limited to authorized personnel, including nursing administration and designated staff. During an observation and interview with the facility Assistant Administrator on 03/02/2026 at 01:53 PM, the central supply room located on the facility's basement floor was inspected. The basement included a resident rehabilitation gym, resident hair salon, and the central supply room. Upon entry, the central supply room door was closed but not locked. The Assistant Administrator, who was responsible for central supply, stated that there were two (2) cabinets where over-the-counter medications were stored. A tan-colored freestanding two- door steel cabinet was observed on the right side of the room. The cabinet was labeled emergency supply cabinet. Two strips of white tape were taped on the cabinet doors above the two keyed swing handles. The cabinet door was not locked. Medications stored inside the cabinet included but were not limited to over-the-counter antacids and painkillers. Another same model cabinet was located on the left side of the room. The door to the second cabinet was also not locked. Medications were stored inside the cabinet included but were not limited to over-the-counter multivitamins, vitamins and mineral supplements, stool softeners, antacids and painkillers. The Assistant stated the cabinets remain unlocked because the central supply room door is locked at all times and only limited staff have access to the supply room.During an interview on 03/02/2026 at 02:13 PM, Maintenance Staff #1 stated they were called to check the central supply room door. Maintenance Staff #1 stated that the central supply room door has a slam shut lock which automatically locks the door upon closing. Maintenance Staff #1 stated that after inspecting the door they found out that the door did not automatically lock upon closing and required repair.During an interview on 03/03/2026 at 01:44 PM, the Director of Nursing Services stated the two medication cabinets in the central supply room should be locked. The Director of Nursing Services stated that the central supply room door should also be locked at all times. The Director of Nursing Services stated the basement was not off-limits to residents as the residents visited the rehabilitation gym and the hair salon in the basement.10 NYCRR 415.18(e)(1-4)

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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. Based on observation, record review, and interviews, the facility did not ensure that it established and maintained an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. This was identified for one (1) (Resident #124) of five (5) residents observed during medication administration. Specifically, during the medication pass observation on 02/26/2026, Licensed Practical Nurse #1 did not perform hand hygiene and administered the eye drops while wearing the same gloves they had used to administer the oral medications and respiratory treatment to the resident. The finding is:The facility policy titled Eye Drop Administration, dated 8/2025, documented eye medications will be administered in a safe and effective manner. The first step in the procedure is to put on examination gloves. The policy did not indicate to wash hands first. The policy states with a gloved finger, gently pull down the lower eyelid to form a pouch and instill the eye drops.Resident #124 was admitted with diagnoses including diabetes mellitus, pneumonia, and anxiety disorder. The 02/10/2026 Annual Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact.During the medication pass observation on 02/26/2026 at 8:55 AM, Licensed Practical Nurse #1 prepared the following medications as per physician's order, at the medication cart, outside Resident #124's room: Losartan 100 milligram tablet, give one tablet at 9:00 AM daily (for hypertension).Glimeperide 4 milligram tablet, give one tablet at 9:00 AM daily (for diabetes).Primidone 50 milligram tablet, give one tablet three times a day (for convulsions).Duloxetine 60 milligram capsule, give one capsule two times a day (for depression).Arnuity Ellipta 200 milligram/actuation powder, one puff, for inhalation at 9:00 AM daily (for asthma).Liquid Protein Supplement (LPS) sugar free 30 milliliter supplement at 9:00 AM daily.Tears Lubricant 0.5% eye drops, instill one drop in each eye every 12 hours.Licensed Practical Nurse #1 prepped the medications at the cart by pouring the Liquid Protein Supplement in a cup, putting the tablets and capsule in a cup, and taking the plastic bag containing the Arnuity Ellipta inhaler out of the drawer. Licensed Practical Nurse #1 then sanitized their hands with a hand sanitizer, put on a pair of gloves, and brought all the medications into the room at the resident's bedside. The resident was repeatedly coughing and complained about coughing too much. The nurse responded that they would provide respiratory treatment now. While wearing the gloves, Licensed Practical Nurse #1 handed the medication cup containing tablets and the capsule to the resident. The resident swallowed the medications and handed the cup back to the nurse. The nurse provided a cup of water to the resident. The nurse then handed the Liquid Protein Supplement cup to the resident. The resident drank the Liquid Protein Supplement and handed the cup back to the nurse. The nurse then took the Arnuity Ellipta inhaler device out of the plastic bag, handed it to the resident, who took one puff of the medication, handed the device back to the nurse, and the nurse then put the inhaler device back in the plastic bag. Wearing the same gloves that were used to administer all the other medications, Licensed Practical Nurse #1 administered eye drops in each eye by pulling down the resident's lower eye lids.During an interview on 02/26/2026 at 12:30 PM, Licensed Practical Nurse #1 stated they were nervous during the medication pass observation and that is why they wore gloves. Licensed Practical Nurse #1 stated they should have removed the gloves and sanitized their hands before administering the eye drops. During an interview on 02/27/2026 at 2:20 PM, the Registered Nurse Infection Preventionist stated Licensed Practical Nurse #1 should have removed their gloves, washed their hands, and put on clean gloves before administering the eye drops. During an interview on 03/02/2026 at 12:20 PM, the Director of Nursing Services stated Licensed Practical Nurse #1 put on the gloves too early. They should have put on the gloves for the eye drops only. The Director of Nursing Services stated the nurse should have removed the old gloves, sanitized their hands, and then put on new gloves before administering the eye drops. 10NYCRR 415.19(b)(4)