

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2025
NAME OF PROVIDER OR SUPPLIER Garden Spring Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1113 North Easton Road Willow Grove, PA 19090	

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)
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Based on facility policy review, review of manufacturer's instructions, clinical record review, observation, and staff interview, it was determined that the facility failed to implement proper infection control procedures regarding the use and disinfection of a multi-use blood glucose meter (BGM) for four of 21 residents that utilized one of two medication carts on the nursing unit. This resulted in an Immediate Jeopardy situation due to an increased likelihood of transmitting bloodborne pathogens between residents who required fingerstick blood glucose testing. (Residents 38, 42, 43, 48) Findings include: Review of the facility policy entitled, Obtaining a Fingerstick Glucose Level, last reviewed October 1, 2025, revealed that blood glucose meters intended for reuse were to be cleaned and disinfected between resident uses according to the manufacturer's instructions and current infection control standards of practice. Review of manufacturer's instructions for the blood glucose meters used by the facility revealed that staff should clean the product with a commercially available Environmental Protection Agency (EPA) registered disinfectant detergent or germicide wipe. Clinical record review revealed that Resident 38 had diagnoses that included diabetes mellitus (a chronic disorder characterized by high blood sugar levels due to the body's inability to produce or effectively use insulin) and viral hepatitis C (a viral infection that can be transmitted via bodily fluids, causes liver swelling, and can lead to serious liver damage). A physician's order dated August 14, 2024, directed staff to administer insulin lispro subcutaneously (insert a needle under the skin) based on a sliding scale (a method of managing diabetes by adjusting insulin doses in response to the individual's current blood glucose levels) four times a day. Clinical record review revealed that Resident 42 had diagnoses that included diabetes mellitus and human immunodeficiency virus (a virus that can be transmitted via bodily fluids and weakens the immune system by attacking and destroying cells that are essential for the body's ability to fight off infection). A physician's order dated December 31, 2024, directed staff to administer insulin lispro subcutaneously before meals based on a sliding scale. Clinical record review revealed Resident 43 had diagnoses that included diabetes mellitus and chronic viral hepatitis C. A physician's order dated September 19, 2025, directed staff to check resident's blood glucose level four times a day on Tuesdays, Thursdays, Saturdays, and Sundays, and three times a day on Mondays, Wednesdays, and Fridays. Clinical record review revealed Resident 48 had a diagnosis of diabetes mellitus. A physician's order dated July 8, 2024, directed staff to administer insulin lispro subcutaneously based on a sliding scale four times a day. Observations on November 5, 2025, at 8:30 a.m., revealed that licensed practical nurse 1 (LPN 1) prepared the blood glucose meter to obtain a blood glucose reading for Resident 48. LPN 1 wiped the blood glucose meter with a 70% isopropyl alcohol wipe and proceeded to use the device to test the resident's blood glucose. LPN 1 then cleaned the blood glucose meter with 70% isopropyl alcohol and put the device back in the top drawer of the cart. Observation of the medication cart that LPN 1 was using was checked at that time and no EPA registered disinfectant detergent or germicide wipes were present. In an interview at that time, LPN 1 stated that she cleaned the blood glucose meter with 70% isopropyl alcohol wipes before and after testing each resident. Observation on November 5, 2025, at 10:07 a.m., revealed that LPN 1 again cleaned the blood glucose meter with a 70% isopropyl alcohol wipe and escorted Resident 38 to his room. In an interview with LPN 1 at that time, LPN 1 confirmed that she was going to use the blood glucose meter used earlier and cleaned with the 70% alcohol wipe to test the blood glucose level of Resident 38. LPN 1 confirmed that she was assigned to the medication cart servicing Residents 38, 42, 43, and 48 and that the blood glucose meter on the cart would be used to obtain blood glucose levels for all residents in the assigned rooms who required blood glucose checks. In an interview on November 5, 2025, at 10:20 a.m., the Director of Nursing (DON) stated that blood glucose meters were to be disinfected using available EPA germicidal disposable wipes and that blood sugar checks with a blood glucose meter were required when residents had physician's orders for sliding scale insulin. In an interview on November 5, 2025, at 3:00 p.m., the Infection Preventionist confirmed that facility staff were to use EPA germicidal disposable wipes to clean and disinfect the blood glucose meters. On November 5, 2025, at 2:40 p.m., the Administrator and the DON were notified that on November 5, 2025, at 10:07 a.m., the failure to implement proper infection control procedures regarding the proper use and disinfecting of blood glucose meters resulted in an Immediate Jeopardy situation at F880-K and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. The facility presented an acceptable action plan for removal of the Immediate Jeopardy on November 5, 2025, at 6:38 p.m. The facility's action plan contained the following: 1</p>		