STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335287	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Gardens Rehabilitation & Nursing Center L L C	6585 Broadway Riverdale, NY 10471

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 2Number of residents cited:1 Based on observation and staff interviews, the facility did not ensure a resident was cared for in a manner that maintained or enhanced their dignity. This was evident for one (1) of two (2) residents (Resident #28) reviewed for Urinary Catheter out of a total sample of 38 residents. Specifically, Resident #28's urinary catheter tubing was noted to be exposed and visible in the hallway during multiple observations. The findings are:The facility policy titled ?Dignity Policy' last reviewed 01/02/2026 stated the facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in recognition of a person-centered approach. The policy also stated employees shall treat all residents with kindness, respect, and dignity.Resident #28 has an active diagnosis of benign prostatic hyperplasia and Non-Alzheimer's Dementia.The Annual Minimum Data Set assessment dated [DATE] documented Resident #28 had intact cognition and was dependent on staff for bed mobility, toilet use and lower body dressing. The Annual Minimum Data Set also documented Resident #28 had a catheter.The Physician's order last renewed 1/27/2026 documented to monitor urine and record urinary output every shift.The Physician's order last renewed on 01/27/2026 documented to change urinary leg bag daily when out of bed.During observations on 02/09/2026 at 11:16 AM and 02/12/2026 at11:56 AM, Resident #28 was seen in the hallway with a catheter drainage bag in a privacy bag. The catheter tubing was exposed, and light-yellow urine was visible in the tubing, draining into the bag. On 02/12/2026 at 11:57 AM, Resident #28 was observed in the hallway with an exposed catheter tubing. The Registered Nurse Manager #3 was also present during the time of the observation.On 02/12/2026 at 11:56 AM, Registered Nurse Manager #3 was interviewed and stated they were not sure if the catheter tubing should be concealed. Registered Nurse Manager #3 also stated that since there is a privacy bag in place for the drainage bag, it would make sense the catheter tubing is also concealed in order to protect the dignity of the resident.On 02/12/2026 at 12:42 PM, Certified Nursing Assistant #2 was interviewed and stated they usually place the leg bag for Resident #28 in the mornings. Certified Nursing Assistant #2 also stated they had not applied the leg bag for Resident #28 for the past couple of days as Resident #28 was rushing the Certified Nursing Assistant to bring them down to therapy. Certified Nursing Assistant #2 further stated they believe the exposed tubing can be a hazard to Resident #28 as the tubing could get stuck.On 02/17/26 at 9:20 AM, the Director of Nursing Services was interviewed and stated an exposed catheter tubing is a dignity and resident's rights issue. The catheter tubing should have been concealed better around the pants, or a leg bag should have been placed to maintain the residents' dignity. The Director of Nursing Services also stated nursing staff are educated to change the catheter bag when out of bed into a leg bag. If that is not possible, then staff are to ensure a privacy bag is in place. The Director of Nursing Services further stated that they, along with the supervisors and nurses, do rounds on the units to ensure no issues are identified. The Director of Nursing Services stated there is also a physician's order in the electronic medical record, that a leg bag should be placed when a resident with a catheter is out of bed.On 02/17/2026 at 12:35 PM, Licensed Practical Nurse #1 was interviewed and stated that when any resident with a catheter (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comes out of their room, there should be a leg bag in place to protect the resident's privacy. 10 NYCRR 415.5(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 1 Based on observations, interviews, and record review, facility did not ensure that services provided meet professional standards of quality. This was evident for one (1) of five (5) residents (Resident #22) reviewed for Unnecessary Medications out of a total sample of 38 residents. Specifically, Licensed Practical Nurse #2 and Registered Nurse 2 failed to hold and continued to administer Midodrine 8mg to Resident #22 on several occasions, despite having received in-service regarding the protocol to hold Midodrine if systolic blood pressure is greater than 115mm/hg The findings are:The New York State Education Law Article 139, Section 6902 stated the practice of the profession of nursing includes the executing of medical regimens prescribed by a licensed physician. Section 6902 also states the nursing regimen shall be consistent with and shall not vary any existing medical regimen.Resident #22 had diagnoses which included Hypotension, Iron Deficiency Anemia, Anxiety Disorder, and Seizure Disorder.The Quarterly Minimum Data Set assessment dated [DATE], documented Resident #22 was cognitively intact, and required supervisory assistance with Activities of Daily Living.The Physician's Order dated 08/07/2025 documented Midodrine 5 milligram tablet, give 1 tablet every 8 hours for Hypotension (low blood pressure). Monitor blood pressure daily and do not give if systolic blood pressure is greater than 115mm/hg (millimeters of mercury).The monthly Medication Regimen Reviews dated 09/17/2025,10/30/2025, 11/28/2025,12/29/2025 and 01/31/2026 documented the resident had an order for Midodrine 5 milligram 1 tablet by mouth every 8 hours for Hypotension. Protocol was to hold Midodrine if systolic blood pressure is greater than 115mm/hg. Systolic blood pressure was higher than 115mm/hg and yet, Midodrine was not held. Please review the Medication Administration Records and address.Review of Medication Administration Records for September 2025, October 2025, November 20225, December 2025 and January 2026 revealed that Midodrine 5 milligram 1 tablet was not held on several occasions. This included but was not limited to 09/05/2025, 09/19/2025, 09/20/2025, 09/26/2025, 09/28/2025, 10/03/2025, 10/17/2025, 10/26/2025,12/27/2025, 01/10/2026 and 01/24/2026, and Midodrine 5mg was administered when Resident #22's systolic blood pressures ranged from 120mm/hg to 142mm/hg.The in-service lesson plan titled ?Midodrine In-Service' dated and signed by Licensed Practical Nurse #2 and Registered Nurse #2 on 10/08/25, documented nurses are to ensure they read the entire order for the resident and follow blood pressure parameters. The in-service lesson plan also documented nurses are to hold systolic blood pressure is greater than 115mm/hg (millimeters of mercury) before administering Midodrine. On 02/11/2026 at 11:42 AM, an interview was conducted with the unit manager, Registered Nurse #1 who stated that they were aware that the medication nurses are not following the midodrine blood pressure protocol. Registered Nurse #1 also stated that medication nurses were reeducated on proper blood pressure protocol when administering Midodrine for hypotension. Registered Nurse #1 further stated they were unaware that the medication nurses continued to make the same mistakes despite the in-services and close supervision they received from Registered Nurse #1.On 02/13/2026 at 09:59 AM, an interview was conducted with Registered Nurse #2 who explained Midodrine is used for certain residents who have symptoms of low blood pressure. Registered Nurse #2 also stated the unit manager had in-serviced them before regarding the midodrine blood pressure protocol, and they were surprised to find out the same errors were made by them again. Registered Nurse #2 further stated they believe those medications were not administered, and that instead of signing them as held, they signed them as administered. Registered Nurse #2 concluded it was an error on their part, and they were not being careful enough.On 02/13/2026 at 10:15 AM, an interview was conducted with Licensed Practical Nurse #2 who stated they could not understand how the error occurred as they pay close attention when administering medications. Licensed Practical Nurse #2 also stated they believe those medications were not administered, and it could be that they signed them incorrectly. Licensed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse #2 further stated they received an in-service regarding the Midodrine blood pressure protocol but could not explain why they still continued to make same errors.On 02/13/2026 at 10:28 AM, an interview was conducted with the Director of Nursing, who stated nurses were in-serviced regarding the Midodrine protocol, and yet, they continued to make mistakes. The Director of Nursing also stated the unit manager was responsible for supervising nurses and making sure nurses are following plan of care and administering medication based on the physician's order. The Director of Nursing could not explain why nurses continued to make the mistake despite reeducation on the Midodrine protocol. 10 NYCRR 415.11(c)(3)(i)

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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** Number of residents sampled: 5Number of residents cited: 1 Based on observation, record reviews and interviews, the facility did not ensure each resident receives treatment and care in accordance with professional standards of practice. This was evident for one (1) of five (5) residents (Resident #22) reviewed for Unnecessary Medications out of a total sample of 38 residents. Specifically, 1). Resident #22 continued to receive Midodrine 8mg 1 tablet on several occasions when the blood pressure was higher than the required parameters as per the physician's order. The Midodrine protocol was to hold medication if the systolic blood pressure is greater than 115mm/hg and yet, Midodrine was not held on different occasions despite in-services received by medication nurses (blood pressure ranges from 120mm/hg to 142mm/hg), and 2). There was no comprehensive care plan developed to address management of hypotension (low blood pressure).The findings are:1. Resident #22 had diagnoses which included Hypotension, Anxiety Disorder, and Seizure Disorder.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #22 was cognitively intact and required supervisory assistance with Activities of Daily Living.The Physician's Order dated 08/07/2025 documented Midodrine 5 milligram tablet, give 1 tablet every 8 hours for Hypotension (low blood pressure). Monitor blood pressure daily and do not give if systolic blood pressure is greater than 115mm/hg (millimeters of mercury)The monthly Medication Regimen Reviews dated 09/17/2025,10/30/2025, 11/28/2025,12/29/2025 and 01/31/2026 documented the resident had an order for Midodrine 5 milligram 1 tablet by mouth every 8 hours for Hypotension. Protocol was to hold Midodrine if systolic blood pressure is greater than 115mm/hg. Systolic blood pressure was higher than 115mm/hg and yet, Midodrine was not held. Please review the Medication Administration Records and address.Review of Medication Administration Records for September 2025, October 2025, November 20225, December 2025 and January 2026 revealed that Midodrine 5 milligram 1 tablet was not held on several occasions. This included but was not limited to 09/05/2025, 09/19/2025, 09/20/2025, 09/26/2025, 09/28/2025, 10/03/2025, 10/17/2025, 10/26/2025,12/27/2025, 01/10/2026 and 01/24/2026, and Midodrine 5mg was administered when Resident #22's systolic blood pressures ranged from 120mm/hg to 142mm/hg.The in-service lesson plan titled ?Midodrine In-Service' dated and signed by Licensed Practical Nurse #2 and Registered Nurse #2 on 10/08/25, documented nurses are to ensure they read the entire order for the resident and follow blood pressure parameters. The in-service lesson plan also documented nurses are to hold systolic blood pressure is greater than 115mm/hg (millimeters of mercury) before administering Midodrine.On 02/11/2026 at 11:42 AM, an interview was conducted with the unit manager, Registered Nurse #1 who stated they were aware the medication nurses had not been following the midodrine blood pressure protocol. Registered Nurse #1 also stated medication nurses were reeducated on proper blood pressure protocol when administering Midodrine for hypotension. Registered Nurse #1 further stated they were unaware that the medication nurses continued to make the same error despite the in-services and close supervision they received from Registered Nurse #1.On 02/13/2026 at 09:59 AM, an interview was conducted with Registered Nurse #2 who explained Midodrine is used for certain residents who have symptoms of low blood pressure. Registered Nurse #2 also stated the unit manager had in-serviced them before regarding the midodrine blood pressure protocol, and they were surprised to find out the same errors were made by them again. The Registered Nurse #2 further stated they believe those medications were not administered, and that instead of signing them as held, they signed them as administered. Registered Nurse #2 concluded it was an error on their part, and they were not being careful enough.On 02/13/2026 at 10:15 AM, an interview was conducted with Licensed Practical Nurse #2 who stated they could not understand how the error occurred as they pay a close attention when administering medications. Licensed Practical Nurse #2 also stated they believe those medications were not administered, and it could be that they signed them incorrectly. Licensed Practical Nurse #2 further (continued on next page)

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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	stated they received an in-service regarding the Midodrine blood pressure protocol but could not explain why they still continued to make same errors.On 02/13/2026 at 10:28 AM, an interview was conducted with the Director of Nursing, who stated nurses were in-serviced regarding Midodrine protocol, and yet, they continued to make mistakes. The Director of Nursing also stated the unit manager was responsible for supervising nurses and making sure nurses are following plan of care and administering medication based on the of physician's order. The Director of Nursing could not explain why nurses continued to make the mistake despite reeducation on the Midodrine protocol.2. Resident #22 had diagnoses which included Hypotension.The Physician's order dated 08/07/2025, last renewed on 02/01/2026 documented Resident #22 was to receive Midodrine 5 milligram tablet, give 1 tablet every 8 hours for Hypotension. Monitor blood pressure daily and do not give if systolic blood pressure is greater than 115mm/hg (millimeters of mercury). Review of the Medication Administration Records for September 2025, October 2025, November 20225, December 2025 and January 2026 revealed Midodrine 5 milligram 1 tablet was administered.There was no documented evidence that a comprehensive care plan was created for Resident #22 that addressed management of hypotension. On 02/13/2026 at 10:22 AM, an interview was conducted with the unit manager, Registered Nurse #1 who stated the registered nurse on the unit is responsible for developing admission, readmission, quarterly and episodic plans. Registered Nurse #1 also stated Resident #22 was supposed to have care plans developed for cardiac related problems due to their diagnosis of hypotension, however, they missed it. Registered Nurse #1 concluded that the missing cardiac care plan was an oversight. On 02/17/2026 at 2:33 PM, an interview was conducted with the Director of Nursing who stated the Unit Nurse managers are responsible for ensuring care plans are developed and updated accordingly. The Director of Nursing also stated they reviewed Resident #22's record yesterday after they were informed about the missing care plan and found that there was no care plan developed management of hypotension for Resident #22. The Director of Nursing further stated that any cardiac related problems, such as hypotension or hypertension should be reflected on a cardiac care plan. The Director of Nursing concluded that they did not have any care plan issues during their daily interdisciplinary team meeting, and the missing cardiac care plan was an oversight. 10 NYCRR 415.12

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 1 Based on record reviews and staff interviews, the facility did not ensure the attending physician reviewed the resident's total program of care, including medications and treatments, at each visit. This was evident for one (1) of five (5) residents (Resident #22) reviewed for Unnecessary Medications out of a total sample of 38 residents. Specifically, there was no documented evidence that the attending physician evaluated Resident #22's medication regimen and addressed irregularities as identified by the pharmacist. The findings are:Resident #22 had diagnoses which included Hypotension, Iron Deficiency Anemia, Anxiety Disorder, and Seizure Disorder.The Quarterly Minimum Data Set assessment dated [DATE], documented Resident #22 was cognitively intact, and required supervisory assistance with Activities of Daily Living.The Physician's Order dated 08/07/2025 documented Midodrine 5 milligram tablet, give 1 tablet every 8 hours for Hypotension (low blood pressure). Monitor blood pressure daily and do not give if systolic blood pressure is greater than 115mm/hg (millimeters of mercury).The monthly Medication Regimen Reviews dated 09/17/2025,10/30/2025, 11/28/2025,12/29/2025 and 01/31/2026 documented the resident had an order for Midodrine 5 milligram 1 tablet by mouth every 8 hours for Hypotension (low blood pressure). Protocol was to hold Midodrine if systolic blood pressure is greater than 115mm/hg. Systolic blood pressure was higher than 115mm/hg and yet, Midodrine was not held. Please review the Medication Administration Records and address.Review of Medication Administration Records for September 2025, October 2025, November 20225, December 2025 and January 2026 revealed that Midodrine 5 milligram 1 tablet was not held on several occasions. This included but was not limited to 09/05/2025, 09/19/2025, 09/20/2025, 09/26/2025, 09/28/2025, 10/03/2025, 10/17/2025, 10/26/2025,12/27/2025, 01/10/2026 and 01/24/2026, and Midodrine 5mg was administered when Resident #22's systolic blood pressures ranged from 120mm/hg to 142mm/hg.On 02/13/2026 at 10:28 AM, an interview was conducted with the Director of Nursing who stated the pharmacist performs a drug regimen review every month on each resident and recommendations are sent to either the Director of Nursing or the Attending Physician. The Director of Nursing also stated that the pharmacist usually emails them recommendations that are related to nursing, however, the recommendation to the physicians will be documented in the medical records under the assessment tool. The Director of Nursing further stated they reviewed all of the Midodrine recommendations and sent them to the Nurse Manager on the unit to follow up with the medication nurses. The Director of Nursing stated they did not send the Midodrine recommendations to the attending physician for review because they believe the nurses needed to address the errors, not the physician. On 02/13/2026 at 12:23PM, an interview was conducted with the Pharmacist who stated that not all pharmacy recommendations are sent to the physician. The Pharmacist also stated they did not send the Midodrine recommendation to the attending physician because those errors were made by the nursing staff, so they sent them to the Director of Nursing only. The Pharmacist further stated some recommendations are meant for the attending physician, such as labs that need to be addressed by physicians, and they will document them under the assessment tab. The Pharmacist concluded that they continued to send the Midodrine errors to the Director of Nursing for several months and they never contacted anyone verbally regarding this matter because it was not considered urgent. On 02/13/2026 at 12:55 PM, an interview was conducted with the Medical Director who stated the pharmacist sends recommendations to individual doctors, and the doctors will address them accordingly. The Medical Director also stated they do not receive pharmacy recommendations; however, they have meetings with the medical providers regularly to address any medical issues that arise. The Medical Director further stated they were made aware of the Midodrine errors today and they were told they were addressed by the nursing department. The Medical Director concluded that it (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is the responsibility of nurses to follow orders appropriately and any errors should be addressed by the nursing staff.On 02/13/2026 at 01:35 PM, an interview was conducted with the assigned Attending Physician #1 stated they never received any recommendation from the pharmacist via email; however, they have access to electronic medical records where the pharmacist documents irregularities that need to be addressed by them. Attending Physician #1 also stated they were not aware of the Midodrine recommendations, and they do not review the medication administration records. Attending Physician #1 concluded that, even though Midodrine was not held on several occasions, it would not have had any negative impact on Resident #22. 10 NYCRR 415.15(b)(2)(iii)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Number of residents sampled: 5Number of residents cited: 1 Based on observations, record review, and staff the facility did not ensure that Medication Regimen Reviews performed by the Pharmacist were reviewed and acted upon by the attending physician in a timely manner. This was evident for one (1) of five (5) residents (Resident #22) reviewed for Unnecessary Medications out of a total sample of 38 residents. Specifically, the attending physician did not act upon the pharmacist's recommendations dated 09/17/2025,10/30/2025, 11/28/2025,12/29/2025 and 01/31/2026 to address Midodrine that was not held for Resident #22 when systolic blood pressure was greater than 115mm/hg (millimeters of mercury) as per physician's order.The findings are:The facility policy titled Medication Regimen Review' dated 10/24/24 documented the Consultant Pharmacist (the pharmacist) shall review the medication regimen of each resident at least monthly and report any irregularities to the Medical Director, the Director of Nursing and the Attending Physician. The policy further stated the Drug Regimen Review forms will be completed by the physician and nursing department within 30 days from the date of review by the pharmacist.Resident #22 had diagnoses which include Hypotension, Anxiety Disorder, and Seizure Disorder.The Physician's Order dated 08/07/2025 documented Midodrine 5 milligram tablet, give 1 tablet every 8 hours for Hypotension (low blood pressure). Monitor blood pressure daily and do not give if systolic blood pressure is greater than 115mm/hg (millimeters of mercury)The monthly Medication Regimen Reviews dated 09/17/2025,10/30/2025,11/28/2025,12/29/2025, and 01/31/2026 documented Resident #22 had an order for Midodrine 5 milligram 1 tablet by mouth every 8 hours for Hypotension. Protocol was to hold Midodrine if systolic blood pressure is greater than 115mm/hg. Systolic blood pressure was higher than 115mm/hg and yet, Midodrine was not held. Please review the Medication Administration Records and address.There was no documented evidence that the attending physician reviewed and acted upon the irregularities dated 09/17/2025,10/30/2025, 11/28/2025,12/29/2025, and 01/31/2026.On 02/13/2026 at 10:28 AM, an interview was conducted with the Director of Nursing who stated the pharmacist performs a drug regimen review every month on each resident and recommendations are sent to either the Director of Nursing or the Attending Physician. The Director of Nursing also stated that the pharmacist usually emails them recommendations that are related to nursing, however, the recommendation to the physicians will be documented in the medical records under the assessment tool. The Director of Nursing further stated they reviewed all the Midodrine recommendations and sent them to the Nurse Manager on the unit to follow up with the medication nurses. The Director of Nursing stated they did not send the Midodrine recommendations to the attending physician for review because they believe the nurses needed to address the errors, not the physician. On 02/13/2026 at 12:23PM, an interview was conducted with the Pharmacist who stated that not all pharmacy recommendations are sent to the physician. The Pharmacist also stated they did not send the Midodrine recommendation to the attending physician because those errors were made by the nursing staff, so they sent them to the Director of Nursing only. The Pharmacist further stated some recommendations are meant for the attending physician, such as labs that need to be addressed by physicians, and they will document them under the assessment tab. The Pharmacist concluded that they continued to send the Midodrine errors to the Director of Nursing for several months and they never contacted anyone verbally regarding this matter because it was not considered urgent. On 02/13/2026 at 12:55 PM, an interview was conducted with the Medical Director who stated the pharmacist sends recommendations to individual doctors, and the doctors will address them accordingly. The Medical Director also stated they do not receive pharmacy recommendations, however, they have meetings with the medical providers regularly to address any medical issues that arise. The Medical Director further stated they were made aware of the Midodrine errors today and they were told they were addressed by the nursing department. The Medical Director concluded that it (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is the responsibility of nurses to follow orders appropriately and any errors should be addressed by the nursing staff.On 02/13/2026 at 01:35 PM, an interview was conducted with the assigned Attending Physician #1 who stated they did not receive any recommendations from the pharmacist via email, however, they have access to the electronic medical records where the pharmacist documents irregularities that need to be addressed by them. The Attending Physician #1 also stated they were not aware of the Midodrine recommendations, and they do not review the medication administration records. The Attending Physician #1 concluded that, even though Midodrine was not held on several occasions, it would not have any negative impact on Resident #22. 10 NYCRR 415.18(c)(2)