

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Meadowbrook Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 154 North Prospect Avenue Plattsburgh, NY 12901	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51742 Based on record review and interview during a recertification survey, the facility did not ensure the resident representative and the physician was notified when there was a change in condition that required a change in the residents' plan of care, medication, or treatment regimen for 3 (Resident #s 7, 58, and 198) of 3 residents reviewed for resident notification issues. Specifically, (a.) for Resident #7, provider was not notified when resident had a fall with a fracture on 8/20/2024 until the next day. For (b.) Resident #58, representative was not notified of a fall on 8/29/2024 and the need for x-rays for 9 hours; (c.), for Resident #198, representative was not notified when Haldol Lactate Solution 5 MG/ML, give 0.5 mg intramuscularly was ordered and given 4 times on 6/26/2024, 7/12/2024, 7/28/2024 (1 mg), and 7/29/2024. This was evidenced by: The facility policy and procedure titled, Notification of Change in Condition, dated 1/2022 documented, in accordance with State and Federal Regulations, the resident, resident's attending physician, and the resident's representative would be notified when any of the following situations occurs: there is an accident/incident involving the resident which results in injury and had the potential for requiring physician intervention; there is a significant change in the resident's physical, mental or psychosocial status due to life-threatening conditions or clinical complications; there is a need to alter treatment significantly or to commence a new form of treatment, a decision is made to transfer the resident from the facility and/or change the resident's medication regimen. Resident #7 was admitted with diagnoses that included dementia, anxiety, and major depressive disorder. The Minimum Data Set (an assessment tool) dated 7/11/2024, documented the resident was cognitively impaired, usually understands and was understood, and required significant assistance to perform activities of daily living. A progress note dated 8/20/2024 at 7:56 PM documented that Resident #7 had a fall at 7:30 PM on 8/20/2024. A progress note dated 8/21/2024 at 9:32 AM documented that the provider had been notified of Resident #7's fall and subsequent fracture and admission to the hospital. The facility investigation report documented the fall on 8/20/2024 at 7:30 PM and that the physician was notified on 8/21/2024 at 9:00 AM by fax. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: Facility ID: 335438
		If continuation sheet Page 1 of 49

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/2024 at 5:05 PM, Director of Nursing #1 stated the facility recognized a problem with provider notifications. They were trying to reach out to providers by the end of shift in which the incident occurred. They were working on improvement, and expect immediate notification of physician for serious issues and more minor issues by the end of the shift, Resident #58 was admitted with diagnoses type II diabetes mellitus, anemia, and dementia. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, and required significant assistance to perform activities of daily living. A progress note dated 8/29/2024 at 10:00 AM documented physician/practitioner visit for post fall follow up. New order to obtain x-rays of shoulders, hips and pelvis, spine, feet, and skull. A progress note dated 8/29/2024 at 10:27 AM documented a fall note that Resident #58 was ambulating with therapy when they just dropped to the floor. A progress note dated 8/29/2024 at 2:59 PM x-rays being obtained for Resident #58. A progress note dated 8/29/2024 at 7:41 PM documented that the results of the x-rays were available, and the provider gave an order for Resident #58 to be sent via emergency services to the hospital. Also, resident representative was attempted to be notified when unreachable contacted resident second representative. During an interview by phone, on 10/25/2024 at 2:37 PM, Family Representative #1 stated they were not notified Resident #58 had fell , nor that they needed x-rays and were in the hospital overnight. Resident #198 was admitted with the diagnoses of dementia with, anxiety, and Parkinson disease. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact and required assistance to perform activities of daily living. A progress note dated 6/26/2024 documented Resident #198 had a new one dose order for Haldol 5 milligrams/milliliter give 0.5 milligram intramuscularly, for behaviors that was administered. A progress note dated 7/12/2024 documented Resident #198 had a new one dose order for Haldol 5 milligram/milliliter give 0.5MG intramuscularly, which was administered, and restart by mouth haloperidol 0.5 milligrams order. A progress note dated 7/28/2024 documented Resident #198 had a new one dose order for Haldol 5 milligrams/milliliter give 1 milligram intramuscularly and was administered. A progress note dated 7/29/2024 documented Resident #198 had a new order for one dose Haldol 5 milligrams/milliliter give 0.5 milligram intramuscularly, which was administered. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR) for June and July 2024 documented physician's orders dated 6/26/2024 at 6:43 AM and 7/12/2024 at 9:23 PM, for Haldol Lactate Solution 5 milligram/milliliter, give 0.5 mg intramuscularly and 7/28/2024 at 11:00 PM for Haldol Lactate Solution 5 milligram/milliliter, give 1 milligram intramuscularly for one dose each order. The Medication Administration Records documented Haldol Lactate Solution 5 milligram/milliliter, give 0.5 milligram intramuscularly was administered on 6/26/2024 at 6:53 AM, 7/12/2024 at 9:44 PM, and Haldol Lactate solution 5 milligram/milliliter, give 1 milligram intramuscularly was administered on 7/28/2024 at 11:08 PM. Review of the resident's medical record did not include documentation that the resident representative was notified when Haldol Lactate Solution 5 milligrams/milliliter, give 0.5 milligram or 1 mg, intramuscularly was ordered. During an interview by phone, on 10/25/2024 at 4:05 PM, Family Representative #2 stated they had not been notified of intramuscular Haldol orders. During an interview on 10/21/2023 at 11:16 AM, Director of Nursing #1 stated the nursing staff was responsible to ensure the resident representative was notified when there was a change in the residents' condition, and for significant order changes. The resident representative should have been notified of the new orders, after the staff had ensured the resident was safe which could have taken a while, but these instances with Resident #198 must have been missed. 10 New York Codes, Rules, and Regulations 415.3(e)(2)(ii)(b)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51742 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure the resident had a right to be free from physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 (Resident #198) of 2 residents reviewed for restraints. Specifically, Resident #198 had a chair alarm (a pad placed on a chair) hooked to a sensor box that alarmed if a wheelchair resident attempted to stand, and had a seat belt around their lap that the resident was not able to remove when asked and that prohibited the resident from rising independently. This is evidenced by: The policy titled Restraints, dated 01/2020, documented that the facility would consider physical restraint after all other interventions were exhausted; it further documented that the nurse would document each time the restraint was applied and/or removed and the restraint would be discontinued as soon as possible. Resident #198 was admitted to the facility with diagnoses of Lewy Body Dementia (dementia caused by protein build up in the brain), anxiety disorder, and repeated falls. The admission Minimum Data Set (an assessment tool) dated 6/26/2024 documented that the resident was cognitively intact, could be understood, and understand others. It further documented that a bed alarm, a chair alarm, and a wander alarm were used daily. In addition, it documented that the resident had a fall prior to admission and no falls in the facility. The quarterly Minimum Data Set, dated dated dated [DATE] documented that the resident had moderately impaired cognition. The Minimum Data Set indicated the resident was on as needed antipsychotic and antidepressant medication. It further documented that the resident had a trunk restraint, chair that prevented rising, bed alarm, chair alarm, and wander alarm that were used daily. In addition, it documented that the resident had two or more falls, one with injury, while in the facility. The Care Plan focus for adaptive equipment, initiated 6/20/2024, documented interventions/tasks of the following: a perimeter mattress (initiated 7/16/2024), a position change alarm (initiated 6/20/2024), a scoot chair (initiated 7/02/2024), a seat belt on the chair (initiated 8/08/2024), a sensor pad for bed (initiated 7/25/2024), and a wander alarm (initiated 8/05/2024). The Care Plan focus for Least Restrictive device - seat belt on chair/release every 2 hours for 10 minutes for position change for diagnosis of gait instability falls, initiated 8/08/2024 and updated with tolerated seat belt well on 9/04/2024. There was no evidence of documented interventions. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan focus for Least Restrictive downloaded 10/25/2024 had a comment added that indicated it was from 10/02/2024 and documented seat belt effective as gentle reminder to call for assist before self-mobilizing - continued to release belt as resident chooses. It documented goals of: free from restraint complication; medical diagnoses: gait instability, fall risk, Parkinson's ataxia, and Lewy Body Dementia with tonal and truncal body changes; current order to release seatbelt every 2 hours while in chair/awake for 15 minutes and during meals for safety; use of seat belt device would be least restrictive and assessed as such every 30 days. It documented the following interventions/tasks: mobility, monitor and adjust care to avoid negative outcome, monitor for resident response to restraint, no increase contracture, provide rehab to strengthen balance and Activities of Daily Livings and lessen need for restraining device, resident/family given education about policy regarding potential risk and benefit of restraint use (give informed consent), and Representative #2 gave informed consent in progress note dated 8/08/2024. The Order Summary Report documented a Physician Order for Resident #198 to release seatbelt every 2 hours while in the chair/awake; to be removed for 15 minutes and during meals, every 2 hours for safety (ordered 8/08/2024, still active). During an observation on 10/20/2024 at 4:58 PM, Resident #198 was observed sitting in the lounge area in a scoot chair with a lap belt, alarm clipped on, and wander alarm on chair while staff distributed dinner. During an observation on 10/21/2024 at 12:10 PM, Resident #198 was observed with a seat belt across the lap and was calling out for help; staff were observed interacting with the resident between distributing lunch trays to other residents. During an observation on 10/21/2024 at 1:27 PM, Resident #198 was observed in a wheelchair with a seat belt around their abdomen, and the resident was reaching for items near the chair but seemed unable to reach and unable to release seat belt which resulted in frustrated look on the resident's face (furrowed brow, reaching down toward lap belt, and shifting scoot chair closer to items). In addition, a box attached to a string clipped in the middle back area of the resident's clothing was observed and a wander alarm was attached to the scoot chair. During an observation on 10/25/2024 at 8:36 AM, Resident #198 was observed in a scoot chair with a seatbelt, wander alarm, and chair alarm attempting to leave the dining room and being pulled back in the dining room. Seat belt was engaged and last check off for release of the seatbelt was 10/25/2024 at 6:00 AM (order was for release every 2 hours and during meals). Further observation at 8:48 AM revealed Resident #198 eating breakfast in the dining room with the seatbelt engaged in a scoot chair. At 9:03 AM the seatbelt was still engaged, and the resident was being administered their medication. During an observation on 10/25/2024 at 9:15 AM in the dining room with Licensed Practical Nurse #6, they asked Resident #198 to take off the seatbelt and the resident reached down to the belt and felt around to the release mechanism, the resident's hand was trembling, and the resident was not able to remove the belt. The resident seemed to get upset and began shaking more during the attempt to remove the belt and so the resident was thanked for the attempt to prevent further distress. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/2024 after the seatbelt attempt with Licensed Practical Nurse #6, they stated they had released the seatbelt earlier and stated the order required it removed for 15 minutes every 2 hours; the nurse was not able to state that it should be removed for meals and denied knowing that Resident #198 consumed breakfast with the seatbelt engaged the entire time. Licensed Practical Nurse #6 denied monitoring for and documenting potential adverse effects of restraints and psychotropic medication and stated it was not something the nurse had to do or had a place to do in the chart of the resident. During an interview on 10/25/2024 at 9:24 AM, Certified Nurse Aide #4 stated Resident #198 was typically out of it (lethargic) before lunch for a couple of hours and generally agitated around 2:00 PM. They had never seen activities interact with Resident #198 one to one or encourage the resident to engage in activities. Physical therapy used to assist Resident #198 with walking but not anymore and nursing staff are too busy. During an observation on 10/25/2024 at 9:54 AM, Resident #198 was in the scoot chair and drowsy. During an interview on 10/25/2024 at 4:05 PM, Family Representative #2 stated the facility called to discuss the seatbelt and medications, but the only information given was benefits of the interventions and no risks were ever discussed. They voiced concern about Resident #198 not having enough to do to keep busy and was told by staff the resident could watch television (Rep #2 could not recall the name of the staff member). They stated the staff told them that the alarms on the chair and bed were so staff could respond more quickly and to inform staff if the resident had a fall. During an interview on 10/25/2024 at 5:05 PM, Director of Nursing #1 stated that the seatbelt did not have a separate assessment, but it was re-evaluated every 30 days and documented in the care plan. They stated no orders were required from the physician for the use of the seat belt and alarms because it was a safety intervention. A plan of care progress note dated 6/20/2024 at 3:13 PM documented that a sensor pad for the bed was issued per nursing request. A plan of care progress note dated 6/20/2024 at 3:36 PM documented that a position change alarm was issued per nursing request. A nurse progress note dated 6/24/2024 at 5:52 AM documented that the resident continued to set off the alarm and to place it in the middle of the back to decrease the resident's ability to remove it. A nurse progress note dated 6/24/2024 at 6:56 AM documented that the alarm went off 6 times in 10 minutes as the resident tried to stand and staff tried to have the resident sit back down, the resident punched staff 4 times and tried to hide the alarm cord to keep staff from reattaching it. A behavior progress note dated 6/26/2024 at 3:55 AM documented that the resident kept getting up when they are unable to walk, combative with staff when they try to have resident sit down. The resident screamed for help and policy loudly when positioned in scooter chair and chair reclined so the resident couldn't get up. The resident tried to tip the chair over to get out of it. A physician progress note dated 7/22/2024 at 10:15 PM documented that the resident accused staff of physical abuse and not allowing the resident to move around. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note dated 7/25/2024 at 12:28 AM documented that a motion sensor was placed on the windowsill in the room due to a fall. A physician progress note dated 07/25/2024 at 1:26 PM documented that the resident removed their gown that had the position alarm attached, so it did not sound when the resident fell . The Treatment Administration Record for 8/2024 revealed no documentation that the seatbelt was released on the following dates: 08/10/2024 12:00 PM 08/10/2024 2:00 PM 08/11/2024 at 8:00 AM 08/11/2024 at 10:00 AM 08/11/2024 at 12:00 PM 08/15/2024 at 8:00 AM 08/15/2024 at 10:00 AM 08/15/2024 at 12:00 PM 08/15/2024 at 2:00 PM 08/20/2024 at 8:00 AM 08/24/2024 at 8:00 AM 08/24/2024 at 10:00 AM 08/24/2024 at 12:00 PM 08/24/2024 at 2:00 PM 08/29/2024 at 8:00 AM 08/29/2024 at 10:00 AM The Treatment Administration Record for 9/2024 revealed no documentation that the seatbelt was released on 9/17/2024 at 2:00 PM. The Treatment Administration Record for 10/2024 revealed no documentation that the seatbelt was released on 10/13/2024 at 2:00 PM. The Medication Admin Audit Report for 10/14/2024 - 10/22/2024 documented the following: (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/15/2024 8:00 AM release was documented as done at 9:08 AM 10/15/2024 10:00 AM release was documented as done at 9:37 AM 10/15/2024 12:00 PM release was documented as done at 12:40 PM 10/15/2024 2:00 PM release was documented as done at 1:18 PM 10/15/2024 4:00 PM release was documented as done at 6:17 PM 10/15/2024 6:00 PM release was documented as done at 6:20 PM 10/16/2024 8:00 AM release was documented as done at 1:46 PM 10/16/2024 10:00 AM release was documented as done at 1:47 PM 10/16/2024 12:00 PM release was documented as done at 1:47 PM 10/16/2024 2:00 PM release was documented as done at 1:47 PM 10/17/2024 6:00 PM release was documented as done at 9:09 PM 10/17/2024 8:00 PM release was documented as done at 9:09 PM 10/17/2024 10:00 PM release was documented as done at 9:09 PM 10/18/2024 4:00 PM release was documented as done at 7:41 PM 10/18/2024 6:00 PM release was documented as done at 7:41 PM 10/19/2024 10:00 AM release was documented as done at 11:31 AM 10/19/2024 12:00 PM release was documented as done at 11:48 AM 10/19/2024 6:00 PM release was documented as done at 7:04 PM 10/19/2024 8:00 PM release was documented as done at 7:04 PM 10/20/2024 8:00 AM release was documented as done at 9:49 AM 10/20/2024 10:00 AM release was documented as done at 9:49 AM 10/20/2024 6:00 PM release was documented as done at 7:49 PM 10/20/2024 8:00 PM release was documented as done at 7:49 PM 10/21/2024 4:00 PM release was documented as done at 10:28 PM (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/21/2024 6:00 PM release was documented as done at 10:28 PM 10/21/2024 8:00 PM release was documented as done at 10:28 PM 10/21/2024 10:00 PM release was documented as done at 10:28 PM 10/22/2024 10:00 AM release was documented as done at 1:34 PM 10/22/2024 12:00 PM release was documented as done at 1:34 PM 10/22/2024 2:00 PM release was documented as done at 1:34 PM 10/22/2024 4:00 PM release was documented as done at 6:57 PM 10/22/2024 6:00 PM release was documented as done at 6:57 PM 10/22/2024 8:00 PM release was documented as done at 7:02 PM During an interview on 10/25/2024 at 9:03 AM, Licensed Practical Nurse #6 stated they did not know where the informed consent was located for Resident #198's seat belt, position alarms, wander alarm, and psychotropic medication. They stated they would ask. During an interview on 10/25/2024 at 9:11 AM, Licensed Practical Nurse #6 stated that per Assistant Director of Nursing #1, all consent was documented in progress notes. They further stated that Resident #198 released the safety belt without assistance. 10 New York Codes, Rules, and Regulations 415.4(a)(2-7)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538 Based on observation, interviews, and record review conducted during recertification and abbreviated survey (NY00329299), the facility did not ensure that the development and implementation of comprehensive person-centered care plans included measurable objectives and timeframes to meet residents' medical, nursing, mental, and psychosocial needs for 5 (Residents #76, 104, 119, 139, and 177) of 44 residents reviewed for comprehensive care plans. Specifically, (a.) Resident #76 care plan interventions were not implemented based on recommendations from the interdisciplinary team to reduce falls and injuries after a fall and the resident had subsequent falls, (b.) Resident #104 care plan did not include interventions and goals for dementia care, (c.) Resident #119 had fallen several times and the care plan was not developed for falls, (d) a Certified Nurse Aide did not follow care plan and transferred Resident #139 alone that caused injury, and (e) Resident #177 fell when staff did not follow resident care plan for transfers. This is evidenced by: A review of the facility policy titled, Activities of Daily Living Assistance and Supervision, last revised 1/08/2024, documented that the facility would ensure that a plan of care for receiving Activities of Daily Living assistance and/or supervision was incorporated into the daily nursing care of each resident. The policy further documented the Nursing Assistant provided Activities of Daily Living assistance/supervision to assigned residents and assists other Nursing Assistants in giving care as needed. A review of the facility policy titled, Care Planning, last revised 1/22/2019, documented the Kardex, which would be developed, revised, and utilized by the interdisciplinary team as a guide to providing care to the resident. The Kardex would be made available either printed and placed in a designated location in the resident's room or electronically. Resident #104 was admitted to the facility with diagnoses of polymyalgia rheumatica (an inflammatory disorder that causes muscle pain and stiffness); failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity); and dementia (loss of memory, language, problem-solving and other thinking abilities). The Minimum Data Set (an assessment tool) dated 09/2024, documented the resident had moderately impaired cognition, could be understood, and understand others. During an observation on 10/20/2024 at 06:09 PM, Resident #104 was sitting in the common area of the unit. They appeared confused, reaching out to the?writer and staff, conversation was unintelligible. On 10/22/2024 at 9:44 AM, resident #104 was observed in the?common area and appeared confused, reaching out and restless in the?chair. Physician Progress note dated 9/30/2024 at 3:46 PM documented a past medical history of Dementia, depression, failure to thrive, Hypertension; polymyalgia rheumatica. Resident had frequent falls and skin tears in the last month. A review of care plans on 10/22/2024 at 12:10 PM, there was documented care plans for dementia and depression were not present in Point Click Care (documentation tool) for Resident # 104. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #119 was admitted to the facility with diagnoses of legally blind (sees shadows only); Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs. and dementia (loss of memory, language, problem-solving, and other thinking abilities). The Minimum Data Set, dated dated ,d+[DATE], documented the resident was cognitively impaired. During record review, a nurse's note dated 9/28/2024 at 10:09 AM documented Resident #119 returned from the emergency room where they were sent for further evaluation status post fall with head trauma. The hematoma (a collection of blood that pools outside of blood vessels in an organ, tissue, or body space) in the?area remained unchanged. The discharge report from the?hospital?was unremarkable with no issues to note and no new orders. During a record review on 10/22/2024 at 12:10 PM, there was no documented care plan for falls in Point Click Care (documentation tool) for Resident #119. Resident #139 was admitted to the facility with diagnoses of essential hypertension, cerebral vascular disease with deficits (stroke), and chronic kidney disease. The Minimum Data Set, dated dated dated [DATE], documented the resident had moderately impaired cognition could be understood, and understand others. A review of abbreviated survey #NY00329529 dated 12/3/2023 documents that the Certified Nursing Aide #6 transferred the resident alone which caused a skin tear to the resident's right leg. A review of the facility investigation dated 12/3/2023 documents the facility investigated the incident and determined that the Certified Nurse Aide #6 attempted to transfer the resident on their own causing a V shaped skin tear to the resident's lower right leg. The Certified Nurse Aide #6 statement documented that the resident care card documented resident was to be transferred by two staff personnel. The facility took a statement from Resident #139 who stated that the aide attempted to put them to bed alone and their leg got caught in the wheelchair. A review of the resident's care plan for Activities of Daily Living documented that the resident was to have two individuals assisting in all transfers. During an interview on 10/22/2024 at 10:47 AM, Resident #139 could not recall the incident where they received the injury. An interview on 10/23/2024 at 01:35 PM with Certified Nurse Aide #6 was attempted unsuccessfully. During an interview on 10/25/2024 at 10:57 AM, Director of Nursing #1 along with Assistant Director of Nursing #1 stated based on daily reports retrieved from 24-hour nursing report and nursing staff, yellow communication sheets were generated with new condition and intervention. These yellow communication sheets sent daily trigger updates to care plan that were overseen by each interdisciplinary team. They stated both Director of Nursing #1, and Assistant Director of Nursing #1 were responsible for updating nursing care plans. 10 New York Codes, Rules, and Regulations 483.21(b)(1) 48413 (continued on next page)		

Department of Health & Human Services
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48615 51131		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51131 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure comprehensive care plans were reviewed after each assessment and revised based on changing goals, preferences and needs of the resident and in response to current interventions for 4 (Resident #'s 50, 53, 76, and #177) of 44 residents reviewed. Specifically, (a.) for Resident #53, the comprehensive care plan for Clotridoides or Clostridium difficile infection (a bacterium that causes diarrhea and inflammation of the colon) was not updated when the infection had resolved; (b.) for Resident #76, the fall care plan was not revised after the most recent Minimum Data Set Assessment; the comprehensive care plan for behaviors did not include a psychiatric consult or on-going psychiatric services; the comprehensive care plan for altercations was not updated after visiting restrictions were lifted for spouse; and the comprehensive care plan for wandering/elopement was not updated to reflect removal of the resident's wander guard; (c.) for Resident #177, the comprehensive care plan for mood was not revised to include psychiatric consult or ongoing psychiatric services. This is evidenced by: The policy titled Comprehensive Care Planning dated 11/02/2023 documented the care plan was a continuous process and was modified and updated on a regular basis to meet the patient/resident's changing needs. Resident #53 Resident #53 was admitted to the facility with the diagnoses of hypertension (high blood pressure), hyperlipidemia (high level of cholesterol in the blood), and Clotridoides or Clostridium difficile infection. The Minimum Data Set (an assessment tool) dated 9/01/2024 documented the resident could usually understand others, was usually understood by others, and had a moderate cognitive impairment. The Medication Administration Record for October 2024 documented the resident was not administered antibiotics for a Clotridoides or Clostridium difficile infection. During an interview on 10/25/2024 at 10:32 AM, Registered Nurse #3 stated they were the manager of the unit. They stated it was their job to enter the care plans in the computer and stated they were about a week behind with entering care plans because they had 30 new admissions this month [October]. During an interview on 10/25/2024 at 3:10 PM, Minimum Data Set Coordinator Director #1 stated care planning was done by the unit managers. Resident #76 (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 76 was admitted to the facility with diagnoses of Alzheimer's Disease (a degenerative neurological disease-causing memory loss), Dementia with behavioral disturbances (a degenerative neurological disease-causing memory and behavioral changes), and Anxiety (an emotional response to stress). The Minimum Data Set, dated dated [DATE] documented the resident could be understood, and usually understands others, and was moderately cognitively impaired. The comprehensive care plan for falls initiated on 2/13/2024 and revised on 9/02/2024 documented that Resident #76 was a fall risk. The goal listed was resident will not sustain serious injuries as a result of fall/accident/incident through the review period. Interventions included, accident and injury review/safety plan follow up; resident education; improved positioning, proper footwear, asking for help when needed, call light placed in reach, allow resident to proceed at their own pace, encourage safety precautions, see adaptive device care plan for safety device use, discuss changes in resident status and explore alternative measures on care plan during accident and injury report. The care plan did not include revisions for falls that occurred on 9/11/2024 or 10/11/2024. A medical progress note dated 10/11/2024 at 1:41 PM documented an evaluation for a reported fall. Physician documented Resident #76's bed was in lowest position, resident had socks on their feet, but their shoes were out of reach. The Physician documented that Resident #76 was getting up to go to the bathroom and was found sitting on the floor at bedside. Resident #76 was calling out for their spouse and a Certified Nurse Aide heard them and went to check, finding Resident #76 on the floor. The Physician recommended Physical Therapy evaluation for balance and coordination. A Plan of Care note dated 10/11/2024 at 3:46 PM documented Resident #76 was heard calling out for their spouse by a Certified Nurse Assistant. The resident was found seated on the floor by the side of their bed. The Physical Therapist documented the bed was in lowest position, the bedding pulled back, and the resident was wearing regular socks. Physical Therapy's conclusion stated the resident slid out of bed while trying to get up to go to the bathroom. Recommendations for corrective measure/revised plan of safety documented were non-skid socks or shoes over regular socks and revised toileting plan. The Comprehensive Care Plan for falls dated 2/13/2024 and last revised 9/02/2024, was not revised to include the recommended corrective measures by Physical Therapy on 10/11/2024 and the non-skid socks. A medical progress note dated 9/11/2024 at 12:47 PM documented that Resident #76 was seen and examined as a post fall follow-up for a fall which occurred on 10/11/2024. The Physician documented Resident #76 did not have any injuries from the fall. Recommendations were to continue to monitor and maintain fall and safety precautions, continue Physical Therapy and Occupational Therapy and continue frequent checks. There was no documented intervention on the 9/11/2024 care plan. A plan of care note dated 9/12/2024 at 2:34 PM documented recommendations for corrective measures and revised plan of safety included footwear appropriate at bedtime toileting, needs frequent checks, offer assistance with toileting earlier during day and night; staff education regarding grip socks at bedtime, prompt toileting needs every two hours; resident education regarding footwear, and use of call light. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Care Plan for falls for Resident #76 initiated 2/13/2024 and last revised 9/02/2024 was not revised to reflect interventions for the fall that occurred on 9/11/2024 nor was it revised for the recommended corrective measures by Physical Therapy on 9/12/2024. During an interview on 10/21/2024 1:30 PM, Licensed Practical Nurse #5 was asked how staff knew what position the bed height for Resident #76 should be per the comprehensive care plan and safety plan. Licensed Practical Nurse #5 stated the bed should be at knee-height and the safety mats should not be on the floor because they caused Resident #76 to trip and increased the resident's risk for falls. Licensed Practical Nurse #5 tried to look up the intervention in Resident #76 care plan in Point Click Care but could not find it. During an interview on 10/25/2024 at 2:20 PM with Registered Nurse #1, they stated that Resident #76 had multiple falls. Registered Nurse #1 stated that the resident had leg pain, but Zyprexa has helped with that. Registered Nurse #1 was asked what medication Resident #76 received to alleviate pain. Registered Nurse #1 stated they had Tylenol ordered for pain and that it was effective. Registered Nurse #1 stated that Resident #76 had more frequent falls because they became agitated and restless when their spouse came to visit. Resident #76 would wander and pace the hallways after the visit and had tripped over things. Registered Nurse #1 stated the resident attempted to get up by themselves in their room and had tripped on items in the room while trying to get to the bathroom. Registered Nurse #1 stated that Resident #76 should always have their bed in the lowest position to the ground and safety mats should always be in place next to the bed. Registered Nurse #1 stated that resident usually slept late in the morning and would get up to eat breakfast. Resident #76 went back to their room and returned to bed right after breakfast and medications, usually sleeping until anywhere from 3 PM to 5 PM. Resident #76 usually woke up to eat dinner and then wandered around the unit for a while. Registered Nurse #1 stated that Resident #76 usually returned to bed and slept through the night unless they had to get up to use the bathroom. The Comprehensive care plan for behaviors, initiated 2/13/2024 and revised on 9/02/2024, documented Resident #76 had the potential to be aggressive related to dementia. Goals included resident will not harm self or others, resident will be free of adverse effects and excessive use of psychotropic medications. Interventions included assess coping skills and support system; intervene before agitation escalated, guide away from source of distress; engage calmly in conversation; if response was aggressive staff were to walk away calmly and reapproach later; have two staff members if needed; meet with resident/family/caregivers to discuss behaviors and identify triggers to the behavior as well as what interventions de-escalate behaviors; modify environment in attempt to de-escalate behavior; monitor for side effects of psychotropic medications; monitor interaction and proximity to others when agitated. The comprehensive care plan did not include a psychiatric consult or on-going psychiatric services. During general observations, on 10/20/2024 at 6:18 PM Resident #76 was observed to be in bed sleeping. During general observations on 10/24/2024 at 11:30 AM, Resident #76 was observed to be in bed sleeping. During general observations on 10/24/2024 at 4:30 PM, Resident #76 was observed to be in bed sleeping. During general observations on 10/25/2024 at 2:30 PM Resident #76 was observed to be in bed sleeping. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical orders dated 10/25/2024 documented that Resident #76 was on multiple psychotropic medications. Resident #76 was ordered Zyprexa 2.5 milligrams two times per day for dementia with behavioral psychological symptoms of dementia. Resident #76 was also ordered Trazodone 50 milligrams, half a tablet two times per day for restlessness/anxiety and Trazodone 50 milligrams one full tablet one time per day for agitation. On 10/23/2024, Ativan 0.5 milligrams every six hours by mouth as needed for agitation was ordered. Resident was also taking medications with the side effect of sedation. The medications listed were Gabapentin 100 milligrams by mouth two times per day for pain; Donepezil 10 milligrams one time per day for Alzheimer's; and Namenda 10 milligrams one time per day for Alzheimer's. The Medication Administration Record dated 10/01/2024 through 10/31/2024 documented administration of Zyprexa and Trazodone daily. The medication administration record also documented the addition of Ativan as needed for anxiety on 10/23/2024. A social services quarterly evaluation dated 8/16/2024 at 11:29 AM completed by Director of Social Work #1, documented that Resident # 76 had never been seen in the facility by a Psychiatrist and no Psychiatric consult had been made for the resident. The comprehensive care plan for behaviors initiated 2/13/2024 and revised 9/02/2024, did not contain an intervention for psychiatric consult or on-going psychiatric services. The comprehensive care plan for altercations, initiated 7/11/2024 and revised on 9/02/2024, documented Resident # 76 had an incident between the resident and their spouse on 7/11/2024. The documented goal was no further altercation will occur through the next review date. Interventions included evaluate situation, environment, risk factors and participating events; spouse to visit when able to be accompanied by another person ie; family, friend, Ombudsman, facility staff. The comprehensive care plan did not reflect care plan changes after visiting restrictions were lifted for the resident's spouse. A progress note dated 7/07/2024 at 12:00 PM documented that a Licensed Practical Nurse was standing at the nurse's station with the Primary Care Manager when they overheard hollering in the North Dining Room. The progress note documented the Charge Nurse went to the dining room and observed Resident #76 pull out a chair at the table and accidentally bump into their spouse. Resident #76's spouse yelled at them that they were stupid and raised their fist appearing to intend to strike Resident #76. Resident #76 was documented to be visibly upset. Registered Nurse #1 requested the spouse to leave the facility. Resident #76 was documented as being upset for some time. A progress note dated 7/11/2024 at 12:39 PM by Licensed Practical Nurse #5 documented a Certified Nurse Assistant reported they observed Resident #76's spouse hitting Resident #76 in the upper right thigh. Licensed Practical Nurse #5 asked Resident #76's spouse to leave the facility. The progress note documented that Director of Nursing #1 and Primary Care Manager were made aware. A social work note dated 7/11/2024 at 1:37 PM, Director of Social Work #1 documented they were made aware of the incident. For increased safety measures, a plan was implemented for Resident #76 to visit with their spouse only when another person was able to accompany Resident #76's spouse during the visit. Director of Social Work #1 initiated a care plan for altercations on 7/11/2024. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/24/2024 at 12:00 PM, Director of Social Work #1 stated that Resident #76's spouse had been escorted from the facility related to abusive behavior toward resident on 7/07/2024 and 7/11/2024. Director of Social Work #1 denied knowledge of a history of domestic violence and stated they felt Resident #76's spouse was ill during those visits, as they had a pacemaker implanted soon after the altercation. Director of Social Work #1 stated they attributed the spouse's behavior to their physical condition at the time. From 7/11/2024 to present, Resident #76's spouse was asked to visit only with another family member and to remain under supervision while visiting. Approximately 2 weeks ago, Director of Social Work #1 decided with Resident #76's adult child, that Resident #76's spouse could come back without supervision as long as they limited their visits to shorter periods. Since that time, Director of Social Work #1 stated that the spouse was behaved and had been leaving after two hours. The comprehensive care plan initiated 7/11/2024 and revised 9/02/2024 did not reflect the change of supervision requirement for the spouse of Resident #76. The Comprehensive care plan for Wandering/Elopement, initiated 2/14/2024 and revised on 9/10/2024, documented Resident #76 was an elopement risk/wanderer related to their disorientation to place. The documented goal was the resident's safety will be maintained through the review date. Interventions included, attempt to determine a trigger to elopement seeking or wandering behavior; identify room with name or familiar item to aid in location of room; and monitor wandering behavior and attempt to identify pattern, frequency, and intensity. The comprehensive care plan for wandering/elopement was not updated to reflect the removal of the resident's wander guard on 9/17/2024. During general observations on 10/20/2024 at 6:18 PM, Resident #76 was observed to be laying across the bed, at floor height. Resident did not have a wander guard in place. The plan of care note dated 9/17/2024 at 3:39 PM by Physical Therapy documented that the Accident and Injury Team discontinued Resident #76's wander guard and care plan was updated. A social work note dated 9/19/2024 at 3:59 PM by Director of Social Work #1 documented that the wander guard was discontinued per the Accident and Injury Team. The wandering and elopement care plan would remain in place for the time being and be updated as needed. A social work note dated 10/17/2024 at 10:09 AM by Director of Social Work #1, documented Resident #76 was at a supervision level for transfers and ambulation which put them at risk to wander. Director of Social Work #1 documented that the wander guard remained in place. Director of Social Work #1 further documented that Resident #76 was found in another resident's room and was easily redirected back to their own room without further incident. A progress note dated 9/06/2024 at 8:08 PM documented Resident #76 had increased restlessness and had been pacing back and forth near the Nurse's Station and the elevators. A progress note dated 10/16/2024 at 3:29 AM documented Resident #76 was noted to be in another resident's room. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/24/2024 at 12:00 PM Director of Social Work #1 stated that Resident #76 had their wander guard removed by the Accident and Injury Team on 9/17/2024. Director of Social Work #1 stated that they had made an error in documentation when they documented on 10/17/2024 that Resident #76 continued to have a wander guard in place. Director of Social Work #1 stated that there are no current preventative interventions in place for Resident #76's current comprehensive care plan for wandering. Director of Social Work #1 stated they assumed there was increased monitoring from staff on the unit. The comprehensive care plan did not indicate a wander guard had been in place or the date it had been discontinued. Resident #177 Resident #177 was admitted to the facility with diagnoses of cerebral infarction (bleeding in the brain which leads to weakness and deficits on one side of the body), epilepsy (repeated seizures), and anxiety (an emotional response to stress). The Minimum Data Set, dated dated dated [DATE] documented the resident could usually understand others, could be understood, and was not cognitively impaired. A comprehensive care plan initiated 3/27/2024 and updated 10/23/2024, documented resident behaviors of physical/verbal aggressiveness, being sexually inappropriate, related to anger, dementia, ineffective coping skills, poor impulse control, impaired judgement, and loss of independence. Interventions listed included assess coping skills and support system; encourage social interaction with peers in community areas; explain staff roles and staff responsibility to resident as cognition allows; intervene before agitation escalates, attempt to calm verbally, and re-approach; meet with resident and family to discuss behaviors; modify environment to de-escalate behavior; monitor interactions and proximity to others when agitated; promote independence; provide person-centered interventions; and switch out staff members as required. The facility did not ensure the comprehensive care plan for mood was revised to include psychiatric consult or on-going psychiatric services. A comprehensive care plan for cognition, initiated on 1/11/2024 and revised on 8/08/2024, documented Resident #177 was alert and oriented, however, they had impaired judgement likely related to the cerebral infarction. There was not a listed intervention for behaviors related to psychiatric symptoms of dementia, nor was there a dementia related comprehensive care plan Resident #177 was on multiple psychotropic medications for behaviors with psychological symptoms of dementia. A social service quarterly evaluation dated 10/17/2023 at 10:48 AM documented that Resident #177 had never received psychiatry in the facility and that a follow up psychiatric consult had not been scheduled or completed. The Minimum Data Set, dated dated dated [DATE] documented Resident #177 had verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screams and disruptive sounds.). The Minimum Data Set also identified that Resident #177 exhibited behaviors of rejection of care that were necessary to achieve goals for health and well-being on at least 1 to 3 days per week. The Minimum Data Set further documented that Resident #177 did not have psychological therapy and a consult for psychological therapy was not indicated. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical orders dated 10/19/2023-10/23/2024 documented a diagnosis of depression, unspecified and anxiety. The medical orders documented that Resident #177 was medicated with the psychotropic medication Ativan 0.5 milligrams every 6 hours as need for agitation, prescribed on 10/23/2024. They were also medicated with the psychotropic medication Duloxetine Hydrochloride capsule delayed release particles 60 milligrams one time per day for depression ordered on 2/26/2024. Resident #177 also received the psychotropic medication Seroquel 50 milligrams by mouth two (2) times per day for increased behavioral psychiatric symptoms of dementia. Resident #177 did not have a diagnosis for dementia or behavioral psychiatric symptoms of dementia. Resident #177 did not have any mental health diagnoses apart from depression and anxiety. Medical orders dated 10/19/2023 to 10/23/2024 did not include an order for psychiatric consult or on-going psychiatric services. The medical orders did not include instruction to monitor for sedation or lethargy. During an interview on 10/24/2024 at 11:40 AM Director of Nursing #1 stated that psychotropic medication were subjected to multiple reviews by medical doctor and pharmacy and psychotropic medications were often used for residents with severe behaviors and diagnosis of behavioral psychiatric symptoms of dementia. Director of Nursing #1 stated that Social Work is responsible for all care planning related to behaviors. During an interview on 10/24/2024 at 12:00 PM Director of Social Work #1 stated that psychotropic medications were used to treat behaviors with symptoms of dementia within the facility. Director of Social Work # 1 stated that the care plan for behaviors was completed separately by the Social Work Department and included non-pharmacologic interventions. They stated that medications were reviewed by the primary medical doctor and behaviors were reviewed by the assigned Social Worker. Director of Social Work #1 stated they did not feel Resident #177 needed a psychiatric consult. 10 New York Code of Rules and Regulations 415.11(c)(2)(i-iii) 34630 43805		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews during the recertification survey, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 residents (Resident #104 and 119) of 2 residents reviewed. Specifically, Residents #104 and 119 did not consistently attend meaningful, accommodating activities to maintain their highest practicable quality of life. This is evidenced by: The Facility's Policy and Procedure titled Activities Department, undated, documented its policy was to provide meaningful activities to residents with various cognitive, physical, and social abilities on a regular basis to enhance their quality of life. Include resident in a variety of programming and adapt the event/activity to assist resident in participating within their ability and comfort zone. Resident #104 was admitted to the facility with diagnoses of Polymyalgia Rheumatica (an inflammatory disorder that causes muscle pain and stiffness), Failure to Thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), and dementia (loss of memory, language, problem-solving and other thinking abilities). The Minimum Data Set (an assessment tool) dated 09/2024, documented a Brief Interview for Mental Status (BIMS) score of 09 suggesting resident was moderately impaired. During an observation on 10/20/2024 at 6:09 PM, Resident #104 was sitting in common area on unit. They were confused, reaching out to writer and staff, conversation was unintelligible. During an observation on 10/22/2024 at 9:44 AM, Resident #104 was observed in common area and was confused, reaching out and restless in chair. Physician Progress note dated 9/30/2024 at 15:46pm documented a past medical history of Dementia, depression, failure to thrive, Hypertension; polymyalgia rheumatica. Resident had frequent falls and skin tear in the last on month. During an interview on 10/20/2024 at 6:28 PM, Activities Aide #1 stated for dementia residents they attend same activities as other residents. They could or occasionally would work 1:1 with dementia residents. Currently not a routine thing. During a subsequent interview on 10/24/2024 at 1:25 PM, Activities Director #1 stated resident with dementia and who were unable to participate in general activities were provided with activities on a one-to-one basis, including coloring, fidgeting items, painting, and sensory touch. Resident were also brought to general activities where an activities aide will assist them. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 104's activity log for July 2024 documented Activity participation 5 out of 31 days: 7/05/2024, 7/09/2024, 7/17/2024, 7/12/2024 and 7/28. Dates 7/12/2024 and 7/28/2024 documented Resident 104 participated in a Trivia/Word Puzzle. August 2024 documented 2 days out of 31 activity participation: 8/23/2024 and 8/28/2024. September 2024 documented 2 out of 30 days: 9/17/2024 and 9/17/2024. October 2024 documented 4 out of 24 days to date: 10/7/2024, 10/9/2024 10/15/2024 and 10/20/2024. Resident #119 was admitted to the facility with diagnoses of visual impairment); chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), and dementia (loss of memory, language, problem-solving and other thinking abilities). The Minimum Data Set, dated dated , d+[DATE], documented a Brief Interview for resident was cognitively impaired, could be understood, and understand others. The Comprehensive Care Plan initiated 9/2024 documented Cognition: Alert and oriented. Diagnosis with dementia and delusional disorder. Intervention included validate resident's feelings at the same time emphasizing the importance of involvement. Resident 119's activity log for July 2024 documented Activity participation for 1 out of 31 days: 8/27/2024. September 2024 documented 1 out of 30 days activity participation: 9/17, and October 2024 showed zero days for activity participation. During an interview on 10/22/2024 at 11:47 AM, Activities Aide #1 stated all residents attended the same activities and there was no special accommodation for residents with hearing or visual impairments. During an interview on 10/24/2024 at 1:25 PM, Director of Activities #1 stated Resident #119 enjoyed food activities, such as ice cream socials and snack bar. They were brought to each floor for distribution. 10 New York Codes, Rules, and Regulations 415.5(f)(1)h		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interview during a recertification survey, the facility did not ensure a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection, and prevent further pressure ulcer for 1 (Resident #50) of 44 residents reviewed. Specifically, for Resident #50, the facility did not (1.) complete an accurate assessments and documentation of an unstageable pressure ulcer on the right great toe identified on 9/23/2024 and a wound on the second toe on the left foot identified on 10/14/2024: (2.) physician ordered treatments for the wounds were not administered as ordered: (3.) the resident's care plan did not include measurable objectives and timeframes to promote healing of the wounds. This is evidence by: Resident #50 was admitted to the facility with diagnoses of cerebral infarction (stroke), diabetes, and acute on chronic diastolic (congestive) heart failure). The Minimum Data Set (an assessment tool) dated 9/13/2024, documented the resident had moderate cognitive impairment. The resident was able to make themselves understood and was able to understand others. The Policy and Procedure titled, Pressure Ulcer Prevention, Assessment & Management, reviewed 7/13/2021, documented the facility would strive to prevent unavoidable pressure ulcer development and implement necessary treatment and services to promote healing and prevent infection of existing pressure ulcers. A thorough skin assessment, skin risk assessment and Braden Scale (tool used to identify patients at risk for developing pressure ulcers) assessment would be completed by the registered nurse on admission, readmission, quarterly, with significant change in condition and as needed. The assessment would be documented in the assessment and virtual body modules in the named software of the electronic medical record. Unstageable pressure injuries were defined as full thickness wounds with wound bases covered by dead tissues composed of slough (yellow, tan, gray, green or brown) eschar (tan, brown or black), or both that obscure the depth of the wounds. A stage II pressure ulcer was defined as partial thickness skin loss involving epidermis, dermis, or both. The ulcer was superficial and presented clinically as an abrasion, blister, or shallow crater. There was no slough or eschar. It documented wound treatments would be documented on the treatment accountability record and a weekly assessment would be completed and documented. The Admission/Readmission Nursing Evaluation dated 9/09/2024, Skin/Body check did not document any wounds. The Braden score documented 14, resident was at moderate risk for pressure ulcers. The Care Plan for Potential for Impaired Skin Integrity due to diabetes, revised 10/21/2024, documented the resident would maintain skin integrity through the review period. Interventions documented daily skin inspection with AM and PM care. The Skin/Wound assessment dated [DATE], documented a wound on the right great toe was an unstageable pressure ulcer that measured 1 centimeter by 0.5 cm. The wound bed appearance was not documented. Topical treatment documented skin prep (used to provide a protective film over the skin). (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan for Impaired Skin Integrity, initiated 9/23/2024 and revised on 10/25/2024, documented the resident had an unstageable pressure injury/ulcer on toe. The toe was not specified, and the treatment of the wound was not documented. Care plan interventions documented conduct weekly assessments and report negative findings to the physician. The physician order dated 9/23/2024, documented skin prep to right great toe every day and evening shift. The order was discontinued on 9/25/2024. The treatment order for skin prep to the right great toe was not documented on the Treatment Administration Record dated September 2024. There was no documentation in the Nurse's Notes the treatment was administered. The Podiatry Memo dated 9/25/2024 and addressed to the facility, documented right hallux (big toe) distal ulcer (end of toe). Treatments included no pressure (to the toe) and dry dressing once a day. The physician order dated 9/25/2024, documented dry dressing every day and evening shift. The location of the treatment area was not documented. The order was discontinued on 10/21/2024. The Treatment Administration Record dated September and October 2024, documented dry dressing every day and evening shift. Clean area with soap and water, pat dry and apply dressing. The location of the area to be treated was not documented. The treatment was signed by the nurse as being administered from 9/25/2024 to 10/21/2024. Further review of the Skin/Wound Assessment of the unstageable pressure ulcer on the right great toe, documented: - On 9/26/2024 and 10/3/2024, the wound bed appearance was not documented. Treatment documented skin prep, although it was discontinued on 9/25/2024, and there was a new order for a dry dressing. - On 10/10/2024, the wound bed appearance was not documented. Treatment documented skin prep twice daily and open to air, although the order for a dry dressing was still in effect on 10/10/2024. - There was no documented weekly wound assessment dated [DATE]. The Physician/Practitioner Progress Note dated 10/14/2024 at 7:00 PM by Physician Assistant #1, documented they were called to the bedside at the request of the resident's spouse to discuss the resident's bilateral foot care. Wife reported the resident did not have sores on their feet prior to hospitalization and noticed areas at the tips of the resident's second and third toes on left foot and second toe on the right had some thickening at the tip with mild erythema (redness). Toes of shoes were already cut and using gauze as a cushion on the tips of the affected toes. Physical exam documented hard callous noted on distal tips of toes. Left second toe with granulation (red, bumpy tissue in the wound bed as the wound heals) with no expanding redness, swelling or pain. There was no documentation in Physician Assistant #1's Note dated 10/14/2024 at 7:00 PM, about the unstageable pressure ulcer on the right great toe. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note dated 10/15/2024 at 12:28 AM, documented Physician Assistant #1 was in and there were new orders for LacHydrin 12% lotion (exfoliates and moisturizes skin) to bilateral feet twice daily and bacitracin (antibiotic ointment) to left second toe tip twice daily x 7 days. The Treatment Administration Record dated October 2024, documented a treatment order dated 10/15/2024 for Bacitracin Zinc External Ointment, apply to left second toe tip topically two times a day for skin care for 7 days. Additionally, there was a treatment order for Bacitracin to be applied tip of right big toe two times a day for skin care for 7 days. The orders for the Bacitracin were documented on the record as discontinued on 10/15/2024, and there was no evidence the resident received the treatments. On 10/15/2024, the record documented 9, a code for other/see Progress Notes. The Nurse's Note dated 10/20/2024 at 8:54 PM, documented the resident's family requested the doctor follow up on Monday 10/21/2024, with the resident's foot treatments. The resident was noted with a dime sized ulcer intact/dry on the right great toe and a pinpoint sized intact/dry ulcer on the second toe of the left foot. The nurse would report to the oncoming shift. There was no documented nursing assessment dated [DATE], of the wound on the second toe of the left foot and no documentation the physician was noted of the family member's request for the physician to follow up on 10/21/2024. The Physician Progress Note dated 10/21/2024 at 8:45 PM by Physician #1, documented they saw the resident on 10/21/2024 for lab review. The physician order dated 10/21/2024, documented dry dressing to left great toe every day and evening shift. The Treatment Administration Record dated October 2024, documented the treatment was signed by the nurse as administered from 10/21/2024 to 10/25/2024. During an observation on 10/22/2024 1:43 PM, Resident #50 was sitting in their recliner with their legs elevated and both feet were bare. The right great toe was noted to have a wound on the tip of the toe that covered the entire tip, with redness around the wound. The second toe of the left foot was noted to have a tiny black round wound. The resident stated the nurses did not know what the wound on the second toe of the left foot was and said it got minimal attention. The left great toe was missing, and the resident stated it was amputated due to injury. When asked, the resident stated the nurses were treating the wound on the right great toe. The Daily Nursing Progress Note dated 10/22/2024 at 2:11 PM, skin/wound documented blister right great toe. There was no documentation of the second toe on the left foot. The Physician Progress Note dated 10/22/2024 at 2:21 PM by Physician #1, documented they saw the resident for wound on feet. The big toe on the right had a wound that was 2 centimeters by 1 centimeter with black scab tissue and another small wound on the second toe of left foot. It documented bacitracin was previously applied on right big toe. The resident's wife was present and was anxious that something might be wrong with the foot. An x-ray of the right great toe and left second toe and a podiatrist consult was ordered. The care plan was not updated to include the wound on the second toe of the left foot. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Daily Nursing Progress Note dated 10/23/2024 at 2:21 PM, documented right great toe blister. There was no documentation of the second toe on the left foot. The Report of Consultation dated 10/24/2024 by podiatry, documented the right hallux distal ulcer measured approximately 1.0 centimeters x 0.9 centimeters and was very shallow. Treatment was no irritation of the toe and a simple dressing just to keep the right hallux distal ulcer clean. There was no documentation in the note of the wound on the second toe of the left foot. The Nurse's Note dated 10/24/2024 at 2:45 PM, documented the resident returned from a Podiatry appointment this afternoon with a new order for the right toe ulcer. Dry dressing once a day. There was no documentation of the wound on the second toe of the left foot. The Skin/Wound assessment dated [DATE] at 3:33 PM, documented the wound on the right great toe was a stage 2 pressure ulcer that measured 1 centimeter x 0.9 centimeters with a shallow wound bed. The wound bed appearance documented 100% granulation. Treatment was to cover with dry dressing once a day. The Plan of Care Note dated 10/24/2024 at 4:49 PM, documented a late entry. Podiatry consult. Per unnamed doctor not a pressure ulcer. There was no documentation in the medical record by the physician the wound on the right great toe was not a pressure ulcer and there was no documentation on the Podiatry consults dated 9/25/2024 and 10/24/2024. The Physician Progress note dated 10/25/2024 at 11:51 AM by Physician #1, documented the resident currently had a wound on their feet and the resident's wife was worried about osteomyelitis (infection in a bone). X-rays of the second left toe first right toe had no evidence of osteomyelitis. Physical exam documented healed wound on right big toe. The podiatrist consult was pending. There was no documentation of a wound on second toe of the left foot. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/2024 at 1:24 PM, Registered Nurse #3 stated they were the nurse manager of the unit. They stated there was a wound on the resident's right great toe that was not present upon admission. Registered Nurse #3 reviewed the Admission/Readmission Evaluation dated 9/09/2024 and stated the right great toe wound was not documented. Stated the wound was identified on 9/23/2024 and they believed it was from the resident's shoes and they cut out the toes of the shoes. Stated a Skin Wound Assessment was done on 9/23/2024 and it was an unstageable pressure ulcer and then stated there was a scab over the toe. The surveyor asked Registered Nurse #3 about the wound assessments that did not document the appearance of the wound bed. Registered Nurse #3 reviewed the assessments and then stated they did not document the wound bed appearance. They stated the right great toe wound was identified on the weekend when they were not here. They stated they did an assessment of the right great toe wound on 10/24/2024, and stated the scab came off and it was now a stage 2 pressure ulcer. Registered Nurse #3 stated it was shallow and had granulation. Stated that on 10/21/2024, there was 100 % eschar, it was a black scab. When asked about interventions they stated they put a bed cradle on the bed and the resident had a podiatry consult. They stated the resident was an established patient there. They stated there was no special form to fill out when they identified a pressure ulcer. They stated they would complete an Incident/Accident report for scratches or bruises. Registered Nurse #3 reviewed the physician notes for any evaluation of the wound following identification on 9/23/2024 and they stated they did not see a note until 10/14/2024, when the Physician Assistant #1 came in over the weekend to evaluate wounds on the toes of their right and left foot that the resident's spouse reported were not there prior to hospitalization . They stated the Physician Assistant #1 documented the wound on the right foot had some granulation and ordered to start lac hydrin to both feet twice daily and ordered bacitracin (antibiotic ointment) to right second digit. Registered Nurse #3 stated the last time they saw the resident's left second toe was last week and stated there was a bruise on it. They stated they did not see any documentation about the bruise in a nurse's note or skin wound assessment. They stated, I can get an Accident & Incident for it. They stated an x-ray was done and there was a note from Physician #1 documented today 10/25/2024. 10 New York Code Rules Regulations 415.12(c)(1)		

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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** 48413 Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure that each resident received the necessary respiratory care and services that were in accordance with professional standards of practice for 2 (Resident #'s 9 and 122) of 5 residents reviewed for oxygen administration. Specifically, (a) Resident #9, there was no physician's order for Resident #9's oxygen, and (b) for Resident #122 oxygen delivery was not provided by unlicensed personnel. This is evidenced by: A review of the facility's policy and procedure titled Oxygen Administration, dated 02/2020, documented that a physician's order was required for oxygen use and that oxygen would be initiated per the Medical Directors order or by a nurse in an acute situation. Resident #9 was admitted to the facility with diagnoses of asthma (chronic inflammation of the airways), chronic obstructive pulmonary disease (lung disease characterized by chronic respiratory symptoms and airflow limitation), and acute and chronic respiratory failure (not enough oxygen getting to the body). The Minimum Data Set (an assessment tool) dated 8/13/2024 documented the resident had severely impaired cognition and was on continuous oxygen therapy on admission and while a resident. A review of the facility's policy and procedure titled Oxygen Administration, dated 02/2020, documented that a physician's order was required for oxygen use and that oxygen would be initiated per the Medical Directors order or by a nurse in an acute situation. Supplemental oxygen was not provided as ordered by the physician for Resident #9: A Care Plan focused on Adaptive equipment, initiated on 01/30/2024 documented an intervention/task of Oxygen set up which was initiated on 08/14/2024 and revised on 08/20/2024. A second intervention/task of oxygen setup was initiated on 01/30/2024 and revised on 02/09/2024. It further documented Resident #9's personal transport wheelchair with an oxygen bag, which was initiated on 08/07/2024. The care plan further documented a focus of precautions, initiated 01/30/2024, with an intervention/task of oxygen per medical doctor order, also initiated 01/30/2024. The care plan documented a focus on Physical Therapy Evaluation, initiated 01/30/2024 and revised 08/07/2024 with interventions/tasks of current levels of oxygen per medical doctor order. The care plan documented a focus on altered pulmonary (lung) function because of chronic obstructive pulmonary disease, initiated 06/06/2024, with an intervention/task of oxygen as directed that was also initiated 06/06/2024. During an observation on 10/23/2024 at 8:04 AM, Resident #9 was on oxygen at 2 liters per minute via a nasal cannula. A review of Resident's #9 Treatment Administration Record and Medication Administration Record for October 2024 documented no order for oxygen nor for care of respiratory equipment. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The visual/bedside Kardex for Resident #9 documented instruction to monitor oxygen as directed; resident care instructed oxygen as directed, and under safety, it instructed oxygen per medical doctor order and oxygen set up. The Kardex further instructed under mobility to maintain current levels of oxygen per the?medical doctor's order. There was no current active order for oxygen. The physician progress note dated 10/15/2024 at 6:24 PM documented oxygen saturation at 97% with oxygen at 2 liters per minute. During an interview on 10/25/2024 at 9:24 AM, Certified Nurse Aide 34 stated that they ensured Resident #9 wore the oxygen and it was on the Kardex. During an interview on 10/25/2024 at 5:05 PM, e Director of Nursing #1 stated that Resident #9 should have had?an order for oxygen, and it must have been missed. (b) Oxygen delivery was provided by unlicensed personnel for Resident #122: Resident #122 was admitted to the facility with diagnoses including chronic respiratory failure with hypoxia (a type of chronic respiratory failure that occurs when the body has low levels of oxygen in the blood), type 2 diabetes mellitus (a condition where the body doesn't respond properly to insulin, resulting in high blood sugar levels), and chronic obstructive pulmonary disease with exacerbation (an ongoing lung condition caused by damage to the lungs with a sudden worsening of symptoms). The Minimum Data Set, dated dated [DATE] documented that the resident could be understood and understand others, and the resident had intact cognition for daily living decisions. A review of the Comprehensive Care Plan updated 10/05/2024 documented that?Resident #122 had a risk for altered pulmonary function related to chronic obstructive pulmonary disease. Interventions included administering medications as directed by the?physician and monitoring for adverse effects and effectiveness. A review of?the Medication Administration Records for October 2024 documented that oxygen was administered at 2 liters per minute via a nasal cannula continuously every shift related to chronic obstructive pulmonary disease. During an observation on 10/22/2024 at 12:26 PM, the Certified Nurse Aide obtained the Resident #122's portable oxygen from the resident's room. The Certified Nurse Aide turned on the oxygen bottle, set the flow rate, and placed the nasal cannula on the resident's face. During an interview on 10/23/2024 at 11:25 PM, Certified Nurse Aide #1 stated that they would set liter flows on resident oxygen when needed. They stated that they would change and apply nasal cannula oxygen tubing, when necessary, then would notify the nurse after it had been changed. During an interview on 10/23/2024 at 11:40 PM, Certified Nurse Aide #2 stated that they would make sure the oxygen bottle was always full when they were on portable oxygen. They stated that they would adjust the?resident's oxygen if the flow rate was not set to the correct amount. They stated that they would also change, and label resident tubing as needed. Certified Nurse Aide #2 stated that they would place a resident on their oxygen if they were not on. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/2024 at 12:10 PM, Licensed Practical Nurse #4 stated that it was the nurse's responsibility to place residents on their oxygen and Certified Nurse Aides should not. They stated that they had shown Certified Nurse Aides how to place a nasal cannula on a resident but should not be setting the oxygen flow rate. They stated that it was also the nurse's responsibility to change and label oxygen tubing. During an interview on 10/24/2024 at 11:30 PM, Nurse Educator #1 stated that they did train new Certified Nurse Aides how to put on oxygen cannula however it was up to the nurse to set the flow rate and it is not set by the Certified Nurse Aide. During an interview on 10/24/2024 at 12:30 PM, the Director of Nursing #1 stated that the Certified Nurse Aides were allowed to place residents on their nasal Cannula but were not allowed to set the flow rate or turn on the resident's oxygen. 10 New York Code of Rules and Regulations 415.12(k)(3)(6) 51742		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48615 Based on observation, record review, and interview during the recertification survey, the facility did not ensure residents who required dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) services, received such services consistent with professional standards of practice for 1 resident (Resident #150) of 1 resident reviewed for Dialysis. Specifically, Resident #150 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and after dialysis treatments. This is evidenced by: The facility's Policy and Procedure titled Hemodialysis, reviewed 4/2020, documented: Patients/residents requiring hemodialysis therapy would be transported to the local Renal Center for hemodialysis therapy. A Dialysis Communication Book shall be established for each patient/resident receiving hemodialysis. A pre and post dialysis assessment would be completed and documented in the electronic medical record. Resident #150 was admitted to the facility with diagnoses of end stage renal disease (kidneys no longer work as they should); status post sepsis (a serious condition in which the body responds improperly to an infection), and depression (a low mood or loss of pleasure or interest in activities for long periods of time). The Minimum Data Set (an assessment tool) dated 7/2024, documented resident was cognitively intact, could be understood, and understand others. The Comprehensive Care Plan initiated 07/2024 documented the resident needed dialysis related to end stage renal disease. Interventions included the resident would be free of complications from dialysis through review date; Monitor/Document vital signs, mental status, and appearance of access site before and after dialysis. The 10/2024 Treatment Administration Record documented a physician order that the resident was to attend dialysis on Monday, Wednesday, and Friday; and to monitor arteriovenous fistula/access site left arm every shift. The resident's dialysis communication book did not include documentation of post-dialysis vital signs, weights, or evaluation of the dialysis access site or a signature for 8/09/2024; 8/14/2024; 8/16/2024; 8/26/2024; 8/30/2024; 9/02/2024; 9/06/2024; 9/30/3024; 10/02/2024; 10/09/2024; 10/14/2024; 10/16/2024; and 10/18/2024. There were no forms to document dialysis evaluation for 8/12/2024; 8/19/2024; 8/21/2024; 8/23/2024; 9/04/2024; 9/11/2024; 9/13/2024; 9/16/2024 and 9/23/2024. During an observation and interview on 10/22/2024 at 10:46 AM, Resident #150 was sitting in recliner in their room. They stated they were very tired after dialysis and could only sleep on non-dialysis days. Resident #150 was noted to have a left nephrostomy tube draining small amount dark fluid. Resident #150 stated they were recently in hospital for an infection and returned with tube. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 12:14 PM, Registered Nurse #3 stated Resident #150 was assessed pre and post dialysis but could not account for missing data in dialysis communication book. They stated there was no documentation of pre and post dialysis in Point Click Care (an electronic medical record). During an interview on 10/24/2024 at 10:46 AM, Director of Nursing #1 stated dialysis patients were assessed pre and post dialysis by the nurse on the floor. A physician was notified with any change in condition. The resident's arteriovenous fistula was assessed daily per orders. Resident that had nephrostomy tubes were flushed once every shift by a registered nurse. 10 New York Codes, Rules, and Regulations 415.12(k)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on observation, record review, and interviews during the recertification and abbreviated survey (Case #s NY00326260, NY00329259, NY00334623, and NY340304), the facility did not ensure provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, the facility's minimum staffing levels of Certified Nurse Aides were not met every day on multiple shifts and multiple units, from 10/05/2024 to 10/20/2024. This is evidenced by: The Facility assessment dated [DATE], documented budget and minimum nursing staffing levels needed for each unit during the 7-3 shift (day), 3-11 shift (evening), and 11-7 shift (night), when the resident census was 233: Certified Nurse Aide Shift Unit Beds Budget Minimum 7-3 Shift The Orchards - LTC 38 5 4 Oak Woods - LTC 39 5 4 Chestnut Grove - LTC 38 5 4 Aspen View - LTC 41 5 4 Pine Ridge - LTC 40 5 4 Sub-Acute 37 5 4 3- 11 Shift The Orchards - LTC 38 4 3 Oak Woods - LTC 39 4 3 Chestnut Grove - LTC 38 4 3 Aspen View - LTC 41 4 3 Pine Ridge - LTC 40 4 3 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sub-Acute 37 4 3 11-7 Shift The Orchards - LTC 38 2 1 Oak Woods - LTC 39 2 1 Chestnut Grove - LTC 38 2 1 Aspen View - LTC 41 2 1 Pine Ridge - LTC 40 2 1 Sub-Acute 37 2 1 Nurse Shift Unit Beds Budget Minimum 7-3 Shift The Orchards - LTC 38 2 1 Oak Woods - LTC 39 2 1 Chestnut Grove - LTC 38 2 1 Aspen View - LTC 41 2 1 Pine Ridge - LTC 40 2 1 Sub-Acute 37 2 1 3- 11 Shift The Orchards - LTC 38 2 1 Oak Woods - LTC 39 2 1 Chestnut Grove - LTC 38 2 1 Aspen View - LTC 41 2 1 Pine Ridge - LTC 40 2 1 Sub-Acute 37 2 1 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11-7 Shift The Orchards - LTC 38 1 1 Oak Woods - LTC 39 1 1 Chestnut Grove - LTC 38 1 1 Aspen View - LTC 41 1 1 Pine Ridge - LTC 40 1 1 Sub-Acute 37 1 1 The Policy and Procedure titled, Nursing Staffing Policy, revised 7/26/2024, documented the facility would maintain adequate staffing to meet needed care and services for the resident population. Licensed nursing staff were available to provide and monitor the delivery of resident care services. The Case Mix Index from July 2023 of 1.3 was utilized to determine staffing levels. The standard full capacity staffing levels for each unit per shift was as follows: Sub-Acute Unit: - Day Shift: 4 Licensed Nurses, 5 Certified Nurse Aides - Evening Shift: 3 Licensed Nurses, 4 Certified Nurse Aides - Night Shift: 2 Licensed Nurses, 2 Certified Nurse Aides LTC Units: - Day Shift: 2 Licensed Nurses, 5 Certified Nurse Aides - Evening Shift: 2 Licensed Nurses, 4 Certified Nurse Aides - Night Shift: 1 Licensed Nurse, 2 Certified Nurse Aides The policy documented standard staffing levels for each unit were subject to change based on resident acuity and the facility census. Certified Nursing Assistants (Aides) were available on each shift to provide the needed care and services of each resident as outlined in the residents' care plan. The facility would maintain minimum staffing levels in times of crisis to ensure adequate resident care was delivered in a safe manner. The Patient Care Manager would adjust staffing levels each shift as needed to ensure adequate staffing levels were maintained on each unit. Review of the untitled resident census per unit with census totals documented: DATE 10/05/2024 Census Sub-Acute 30 (continued on next page)		

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

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Orchards 38 Oak Woods 40 Chestnut Grove 38 Aspen View 41 Pine Ridge 41 Total 228 DATE 10/06/2024 Census Sub-Acute 30 The Orchards 39 Oak Woods 39 Chestnut Grove 38 Aspen View 41 Pine Ridge 41 Total 228 DATE 10/09/2024 Census Sub-Acute 36 The Orchards 38 Oak Woods 39 Chestnut Grove 38 Aspen View 41 Pine Ridge 41 Total 233 DATE 10/12/2024 Census Sub-Acute 37 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Orchards 40 Oak Woods 39 Chestnut Grove 38 Aspen View 39 Pine Ridge 41 Total 234 DATE 10/13/2024 Census Sub-Acute 37 The Orchards 40 Oak Woods 39 Chestnut Grove 38 Aspen View 40 Pine Ridge 41 Total 235 DATE 10/14/2024 Census Sub-Acute 36 The Orchards 40 Oak Woods 40 Chestnut Grove 39 Aspen View 40 Pine Ridge 41 Total 236 DATE 10/16/2024 Census Sub-Acute 35 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Orchards 42 Oak Woods 40 Chestnut Grove 40 Aspen View 40 Pine Ridge 42 Total 239 DATE 10/17/2024 Census Sub-Acute 36 The Orchards 42 Oak Woods 40 Chestnut Grove 39 Aspen View 40 Pine Ridge 42 Total 239 DATE 10/20/2024 Census Sub-Acute 33 The Orchards 43 Oak Woods 39 Chestnut Grove 39 Aspen View 39 Pine Ridge 41 Total 234 Review of the untitled staff assignment sheets dated 10/05/2024 through 10/20/2024, documented less than the facility's minimum nursing staffing levels for Certified Nurse Aides on daily 8-hour day, evening, and night shift schedules as follows: (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Saturday 10/05/2024, Sub-Acute Unit evening shift: 1 Registered Nurse, 1 Licensed Practical Nurse, and 3 Certified Nurse Aides (1 aide was scheduled for 3 hours) for 30 residents. - Sunday 10/06/2024, Chestnut Grove Unit day shift: 2 Licensed Practical Nurses and 3 Certified Nurse Aides for 38 residents. - Sunday 10/06/2024, Pine Ridge Unit day shift, 1 Registered Nurse, 1 Licensed Practical Nurse, and 3 Certified Nurse Aides for 41 residents. - Wednesday 10/09/2024, Pine Ridge Unit day shift: 1 Registered Nurse, 1 Licensed Practical Nurse, and 3 Certified Nurse Aides for 41 residents. - Saturday 10/12/2024, Oak Woods Unit day shift: 1 Registered Nurse, 1 Licensed Practical Nurse, and 3 Certified Nurse Aides for 39 residents. - Sunday 10/13/2024, Sub-Acute Unit day shift: 1 Registered Nurse, 2 Licensed Practical Nurses (1 orientee) and 3 Certified Nurse Aides for 37 residents. - Sunday 10/13/2024, The Orchards Unit day shift: 1 Registered Nurse, 1 Licensed Practical Nurse, and 3 Certified Nurse Aides for 40 residents. - Sunday 10/13/2024, Oak Woods Unit day shift: 1 Registered Nurse, 1 Licensed Practical Nurse, and 3 Certified Nurse Aides for 39 residents. - Sunday 10/13/2024, Chestnut Grove Unit day shift: 2 Licensed Practical Nurses and 3 Certified Nurse Aides for 38 residents. - Sunday 10/13/2024, Pine Ridge Unit day shift: 2 Licensed Practical Nurses and 3 Certified Nurse Aides for 41 residents. - Monday 10/14/2024, The Orchards Unit evening shift: 1 Registered Nurse, 1 Licensed Practical Nurse, and 2 Certified Nurse Aides for 40 residents. - Wednesday 10/16/2024, The Orchards evening shift: 1 Registered Nurse (scheduled 4.75 hours), 2 Licensed Practical Nurses, and 2 Certified Nurse Aides for 42 residents. - Thursday 10/17/2024, Pine Ridge evening shift: 1 Licensed Practical Nurse, 3 Certified Nurse Aides (1 scheduled for 4 hours) for 42 residents. - Sunday 10/20/2024, Oak Woods Unit night shift, no licensed nurses were scheduled and 2 Certified Nurses (1 scheduled for 3.83 Hours) for 39 residents. On 10/20/2024 at 6:26 PM, Resident #582 was in common area where they had finished eating dinner. A brace was noted on the resident's right forearm. The resident stated the facility never had enough staff in the early morning or late-night hours. They stated they had to wait 1 hour and 10 minutes. The resident stated they did tell staff when they had to wait that long and staff say, 'Well, we've been busy.' (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/21/2024 at 1:24 PM, Resident #583 stated there were 2 Certified Nurse Aides during the night shift. They stated they were supposed to wait for staff to go to the bathroom but because staff took too long to answer the call light, they would go to the bathroom by themselves. During the Resident Council meeting on 10/21/2024 02:58 PM, residents reported they had to wait a long time on the weekends for their call light to be answered. They reported it took 45 minutes to 1 hour to get assistance. During an interview on 10/21/2024 at 1:32 PM, Resident #105 stated there was never enough staff at dinner time. They stated they were not supposed to get out of bed by themselves but sometimes did when no one came to help. They stated it usually happened at night. They stated they hated to have to call the aides because then they had to stop what they were doing and take care of them (Resident #105). During an interview on 10/21/2024 at 3:10 PM, Resident #3 reported they have been left for over an hour without the staff responding to the call bell after soiling themselves. The resident reported that if their aide went on break, no one answered the call bell. The resident reported they had to change their own clothes and bedding. During an interview on 10/22/2024 at 10:55 AM, Resident #585's family member stated they were in the facility with the resident 10 hours a day because there was not enough staff to help the resident. They stated they would wait for staff to come and help the resident and would help the resident by themselves to the bathroom because it took too long for staff to respond to the call light. They stated they have had to yell for help when they needed staff to come immediately. Stated the facility had been short staffed since the resident was first admitted and stated staffing was worse on the weekend when there were 2 aides for 40 residents. During an interview on 10/25/2024 at 2:45 PM, Registered Nurse #3 stated staffing was easier with 4 nurses than with 2. They stated they usually had 2 medication/treatment nurses, a charge nurse and themselves on the unit. They stated they usually had 4 to 5 aides on dayshift. For evenings they usually had 2 nurses and 4 aides. They were not sure about the night shift staffing. 10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)		

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on observation, record review, and interviews during a recertification survey and abbreviated survey (NY00326260), the facility did not ensure procedures that assured the accurate acquiring, receiving, dispensing, reconciliation, and storage of medications. Specifically, the facility did not ensure that narcotic medications received at the facility were properly destroyed. This is evidenced by: On October 13, 2023, Director of Nursing #1 sent a notification to the New York State Department of Health Bureau of Narcotics advising them of the destruction of controlled substances. A follow-up notification from the manager of the Bureau of Narcotics Enforcement on 10/17/2024 advising the facility that their destruction notification was denied as they did not submit a narcotics license renewal. The manager from the Bureau of Narcotics also issued two statements of deficiencies to the facility for operating without a license and destruction of controlled substances without approval from the New York State Department of Health Bureau of Narcotics. During an interview on 10/24/2024 at 1:45 PM, Director of Nursing #1 stated that they had a specific procedure for the renewal of the controlled substance license for the facility. They stated that they have not had any issues during the [AGE] years they have been the director at the facility. They stated that during that time they were out of the office and working from home due to contracting COVID and did not have access to their files at the facility. They stated that they did not follow their procedure and the renewal was erroneously missed. They stated that they corrected the issue and responded to the Bureau of Narcotics' statement of deficiencies. Director of Nursing #1 stated that they have not had any issues since this incident. Past Non-Compliance Based on the following corrective actions taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance with this specific regulatory requirement at the time of this survey: An application for renewal of their Class 3A license was submitted to the New York State Department of Health Bureau of Narcotics was submitted on 10/17/2023. The facility's controlled substance license was approved effective 10/18/2023 and expires 10/17/2025. The facility's plan of correction to the Bureau of Narcotics for the statement of deficiency included adding the license renewal to the annual audit schedule to ensure timely renewal is completed. A review of the facility's Statement of Deficiencies issued from the New York State Department of Health Bureau of Narcotic Enforcement dated 10/17/2023 documented that a person may destroy controlled substances only after the written approval of the Department which included specific protocols for the destruction. The facility's plan of correction dated 10/18/2023 documented that each request for approval of destruction would be reviewed and verified by two licensed nurses to ensure the destruction had been approved before the destruction of the controlled substance. (continued on next page)		

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Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Many	10 New York Codes of Rules and Regulations 483.45(b)(2)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5% for 3 (Resident #s68, 182 and 199) of 6 residents observed during a medication pass for a total of 34 observations. This resulted in a medication error rate of 38.24%. This is evidenced by: The facility's Policy and Procedure titled Medication Administration reviewed 2/2020 documented Nurses were required to adhere to the following: Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified by the physician. Nurses must take every safety precaution when administering medications. The Five Rights are safety rules to be implemented each time a drug is administered: o Right Medication o Right Patient/Resident o Right Time o Right Route o Right Dose. Resident #68 was admitted to the facility with diagnoses of bacterial Infection, limited mobility and depression. The Minimum Data Set, dated dated dated ,d+[DATE], documented resident was cognitively intact, could be understood, and understand others. Resident #68's current physician orders on the Medication Administration Record dated 10/22/2024 at 12:00 Noon revealed that the resident should receive Intravenous Piperacillin Sod Tazobactam Solution Reconstituted 3.375 milligrams every 6 hours for 7 days for bacterial infection. During an observation on 10/25/2024 at 12:36 PM, Resident #68 was receiving an infusion via right forearm peripheral intravenous site via gravity. Registered Nurse #1 stated the infusion pump did not work, they had tried 3 others and they had been running the infusion by gravity for the last 2 days. Several tiny air bubbles were noted in the tubing. Registered Nurse #1 was asked to provide the rate of infusion and length of infusion. Registered Nurse #1 stated either 100 milliliters or 200 milliliters per hour. Registered Nurse #1 did not provide drip rate per minute when administering gravity infusions. According to manufacturer recommendation: DOSAGE AND ADMINISTRATION ZOSYN should be administered by intravenous infusion over 30 minutes. The usual total daily dose of ZOSYN for adults is 3.375 g every six hours totaling 13.5 g (12.0 g piperacillin/1.5 g tazobactam). https://labeling.pfizer.com/showlabeling.aspx?id=502. During an interview on 10/24/2024 at 10:46 AM, Regional Director of Nursing #1 and Director of Nursing #1 stated all nurses attended general orientation which included medication administration policy and procedures. Each nurse was assigned a preceptor who signed off on demonstrated competencies with medication administration. During an interview on 10/25/2024 at 12:55 PM, Nurse Educator #1 stated all Registered Nurses were signed off on skills including intravenous infusion during preceptorship. Nurse Educator assisted Registered Nurse with infusion for Resident #68. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #182 was admitted to the facility with diagnosis of Parkinson's disease (a movement disorder of the nervous system that worsens over time); hypertension (high blood pressure) and depression. The Minimum Data Set (an assessment tool) dated 9/2024, documented resident was cognitively intact, could be understood, and understand others. Resident #182's current physician orders on the Medication Administration Record dated 10/2024 revealed that the resident should receive the following medications at 08:00AM: Vitamin C 500 milligrams 1 tablet daily; Carbidopa 25-100 milligrams tablet three times daily; Dofetilide 250 micrograms 1 tablet two times daily; Eliquis 5 milligram tablet daily; Iron 325 milligram tablet daily; Metoprolol Extended Release 50 milligrams tablet daily; Potassium chloride 20 milliequivalent 1 tablet daily. A medication observation was conducted on 10/23/2024 at 09:20 AM on the Aspen Unit. Licensed Practical Nurse #1 administered the following medication at 9:35 AM that were scheduled for 8:00AM: Vitamin C 500 milligrams 1 tablet daily; Carbidopa 25-100 milligrams tablet three times daily; Dofetilide 250 micrograms 1 tablet two times daily; Eliquis 5 milligram tablet daily; Iron 325 milligram tablet daily; Metoprolol Extended Release 50 milligrams tablet daily; Potassium chloride 20 milliequivalent 1 tablet daily. Resident #199 was admitted to the facility with diagnosis of diabetes Type 2 (a chronic condition that happens when you have persistently high blood sugar levels); hypertension; (high blood pressure) and depression. The Minimum Data Set, dated dated dated ,d+[DATE], documented resident had severe cognitive impairment. Resident #199's current physician orders on the Medication Administration Record dated 10/2024 revealed that the resident should receive the following medications at 08:00AM: Alpha Lipoic acid 300 milligrams daily; Eliquis 2.5 milligram tablet two times daily; Gabapentin 300 milligram capsule two times daily; Metformin 500 milligram tablet daily; Metoprolol Succinate Extended Release 50 milligrams daily. A medication observation was conducted on 10/23/2024 at 09:20 AM on the Aspen Unit. Licensed Practical Nurse #1 administered the following medication at 9:30 AM that were scheduled for 8:00AM: Alpha Lipoic acid 300 milligrams daily; Eliquis 2.5 milligram tablet two times daily; Gabapentin 300 milligram capsule two times daily; Metformin 500 milligram tablet daily; Metoprolol Succinate Extended Release 50 milligrams daily. During an interview on 10/23/2024 at 9:40 AM, Licensed Practical Nurse #1 stated they were late passing medication because they were the only nurse passing medication for 41 residents. They were always running behind. Licensed Practical Nurse #1 stated they did not notify anyone that the medications were late, because the system informed the Director of Nursing that medications were passed late. Licensed Practical Nurse #1 stated they always gave Resident #199 medications in applesauce because it made it easier and tasted better to the resident. Licensed Practical Nurse #1 was unable to locate order to give medication in applesauce and stated, there was no order. 10 New York Codes, Rules, and Regulations 415.12 (m)(1)]		

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NAME OF PROVIDER OR SUPPLIER Meadowbrook Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 154 North Prospect Avenue Plattsburgh, NY 12901	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48615 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labelled and stored in accordance with professional standards of practice. Specifically, (a.) opened medications had no open and/or expiration dates, and (b) a medication cart was left unattended and unlocked. This was evident for 3 (Aspen, Subacute, and Orchard Units medication carts) out of 3 medication carts reviewed. This was evidenced by: The facility's Policy and Procedure titled Medication Administration reviewed 2/2020 documented Nurses were required to adhere to the following: The expiration date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened should be recorded on the container. During administration of medications, the medication cart would be kept closed and locked when out of sight of the medication nurse. The cart must remain clearly visible to the nurse administering medications. and all outward sides must be inaccessible to others passing by. The nurse should secure the medication cart at all times to prevent unauthorized entry. During an observation and interview on 10/23/2024 at 9:22 AM, Aspen Unit Medication Cart was unattended, unlocked and laptop screen was open with Resident Medication Administration Record displayed. Licensed Practical Nurse #1 returned to cart after approximately 5 minutes of observation. They stated they were running behind and it was a very hectic morning. There was 1 nurse passing medications to 41 residents. During an observation on 10/23/2024 at 10:24 AM, the Subacute Unit Medication Cart contained 1 bottle of Lumigan eye drops with open date of 10/15/2024 and no expiration date; 1 bottle of Dorzolamide 2% eye drops open date of 10/02/2024 and no expiration date. The facility's pharmacy grid of shortened expiration dates found on the medication cart included insulin only. During an observation and interview on 10/23/2024 at 10:50 AM, Orchard Unit, Medication Cart contained 1 FIASP insulin pen with an open date of 10/20/2024 and 1 Aspart insulin pen opened 10/18/2024 both had no expiration dates. Registered Nurse #1 stated the expiration date would be 30 days after opening, which is 2 days beyond the manufacturer's expiration date of 28 days after opening. They were unaware of the facility's pharmacy grid of shortened expiration dates. The medication cart on Orchard Unit also contained 1 glargine insulin pen with no open and no expiration date; 1 bottle of GenTeal eye drops with no open and no expiration dates. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/23/2024 at 11:23 AM, Pine Ridge Unit Medication cart contained 1 Lantus insulin pen with no open and no expiration date; 2 Basaglar insulin pens with no open and no expiration dates; 1 Glargine insulin pen with no open and no expiration date. 1 Anoro Ellipta inhaler opened 10/22/2024 with no expiration date. Licensed Practical Nurse #2 verbalized the expiration date would be 2026 as posted on the box. The facility's pharmacy grid of shortened expiration dates for this medication was 6 weeks after opening. During an interview on 10/24/2024 at 10:46 AM, Regional Director of Nursing #1 and Director of Nursing #1 stated all nurses attend general orientation which includes medication administration policy and procedures. Each nurse was assigned a preceptor who will sign off on demonstrated competencies with medication administration. Each nurse passing medication was responsible to ensure medication cart is clean and orderly. All medications should be labeled clearly with open dates. There was a binder on each cart with manufacturer shortened expiration dates. 10 New York Codes, Rules, and Regulations 415.18(d)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48413 Based on observation and interviews during the recertification survey, the facility did not ensure that food was stored, prepared, distributed, or served in accordance with professional standards for food service safety in 6 of 6 resident unit kitchenettes and main kitchen. Specifically, area of the main kitchen and resident kitchenettes were not clean. This is evidenced by: During observations in the main kitchen on 10/20/2024 at 5:45 PM, the rolling toaster appliance had a large amount of buildup and debris on the device. In a follow up observation on 10/22/2024 at 9:34 AM the rolling toaster was not cleaned and still had a large buildup of debris on the device. During observations on the Orchards 1st Floor Unit on 10/22/2024 at 10:34 AM, the resident kitchenette microwave had food particles along the door and on the interior of the appliance. Door, shelving units, and the bottom of the unit refrigerator was soiled with food and liquid particles. During observations on the Orchards 2nd Floor Unit on 10/22/2024 at 10:46 AM, the resident kitchenette microwave had food particles along the door and on the interior of the appliance. During observations on the Pine Ridge Unit on 10/22/2024 at 11:04 AM, the resident kitchenette microwave had food particles along the door and on the interior of the appliance. During observations on the Aspen View Unit on 10/22/2024 at 11:16 AM, the resident kitchenette microwave had food particles along the door and on the interior of the appliance. The inside top of the microwave appeared melted and discolored. The unit refrigerator seals were cracked, broken, and soiled with food particles and liquid spill. The inside of the door, shelving, and bottom of the refrigerator was soiled with liquid spills and food particles. During observations on the Chestnut Gove Unit on 10/22/2024 at 11:22 AM, the resident kitchenette microwave had food particles along the door and on the interior of the appliance. The unit refrigerator seals, inside of the door, shelving, and bottom of the refrigerator was soiled with liquid spills and food particles. During observations on the Oakwood Unit on 10/22/2024 at 11:34 AM, the resident kitchenette microwave had food particles along the door and on the interior of the appliance. The inside top of the microwave appeared melted and discolored. The unit refrigerator seals were cracked, broken, and soiled with food particles and liquid spill. The inside of the door, shelving, and bottom of the refrigerator was soiled with liquid spills and food particles. During an interview on 10/22/2024 at 10:10 AM, the?Director of Food Services #1 stated that staff should be cleaning the kitchenettes every day and signing off when done. They stated that the areas were to be cleaned by dietician aide #1when they refill the refrigerator with items daily. The Director of Food Services #1 was shown the refrigerators, seals, and microwaves. They stated that they should had not been like that and would had been cleaned or reported to maintenance. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/25/2024 at 11:45 AM, the Director of Housekeeping #1 stated that their staff was responsible for the overall cleaning in the kitchenettes but not inside the refrigerators. They stated that if there was an issue with the appliances and equipment in the kitchenettes they would report it to them and complete a work order for maintenance. The Director of Housekeeping #1 was shown the refrigerators and seals. They stated that they should not have been like that and should had been cleaned or reported to maintenance. They stated that they would discuss the cleaning with their staff. They stated they had not received any work orders or notifications about the microwaves. During an interview on 10/22/2024 at 12:34 PM, the Dietary Aide #1 stated that they are responsible for the cleaning of the kitchenette refrigerators when they perform their daily rounds and refill the refrigerators. They stated that they had been not performing the duties like they are supposed to because of time and the amount of work they must complete in that time. Refrigerators shown to the Dietary Aide #1, and they stated that they should not look like that and should have been cleaned regularly. They stated that the seal on the Aspen View Unit refrigerator should had been reported to maintenance to be fixed. During an interview on 10/22/2024 at 2:30 PM, the Director of Maintenance stated that they had been in the position only 2 months and did not receive any work orders for any refrigerators or microwaves for the facility. They stated they were just made aware of the microwaves and refrigerators that day. They stated that if they were made aware of they would place the issue on the work plan to get completed. 10 New York Codes, Rules, and Regulations 415.14(h)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, interview, and record review during the recertification survey, the facility did not ensure infection prevention control practices were followed to help prevent the spread, development, and transmission of communicable diseases and infection for all residents and staff in facility reviewed for infection control. Specifically, facility staff did not properly use personal protective equipment on units with COVID. This is evidenced by: The Infectious Disease Outbreak Control policy, revised 07/19/2024, all employees would maintain transmission-based precautions as indicated During an observation on 10/22/2024 at 10:34 AM on the subacute unit, a nurse exited a resident room wearing a cloth gown. The nurse removed the gown in the hallway outside of the resident's room. The resident in the room (room [ROOM NUMBER]) was on transmission-based precautions for COVID. During an interview on 10/24/2024 at 10:46 AM, Director of Nursing #1 stated personal protective equipment was located on each unit and it was centrally located. They further stated that staff should carry personal protective equipment to the room and put on the protective equipment in the hall prior to entry and should remove the protective equipment in the room. During observations on 10/20/2024 and 10/21/2024, the cart that stored personal protective equipment was in the common area on the Aspen Unit. No personal protective equipment storage cart was observed on the Orchard unit. During an observation on 10/23/2024 at 8:07 AM outside of room [ROOM NUMBER], there was a special droplet precaution sign on the door and the door was open with a resident sleeping in a wheelchair. During an interview on 10/23/2024 at 8:07 AM, Registered Nurse #4 stated that room [ROOM NUMBER] was on COVID precautions and the door should remain closed. During an observation on 10/23/2024 at 11:21 AM on the subacute unit, the door for room [ROOM NUMBER] was open and had a special droplet precaution sign on the door, and the door for room [ROOM NUMBER] was open and had a special droplet precaution sign on the door as well. During an interview on 10/23/2024 at 11:43 AM, Registered Nurse #3 stated that room [ROOM NUMBER] had a family member positive for COVID and so the resident was on COVID precautions. Staff should take off personal protective equipment, including the isolation gown, in the resident room and discard it into a plastic garbage bag that the staff should carry out of the isolation room and dispose of in dirty storage. During an interview on 10/24/2024 at 4:38 PM, Certified Nurse Aide #5 stated they wear an N-95 mask, then place a surgical mask on top so that when they assist a resident on isolation for COVID they discard the surgical mask and never change the N-95 mask. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/24/2024 at 4:50 PM, Licensed Practical Nurse #7 was observed wearing one strap of the N-95 mask and the other strap was between the mask and their cheek, preventing a seal. They stated the October 2024 in-service was posted to sign and it addressed infection control, including proper personal protective equipment use. During an observation on 10/24/2024 at 4:49 PM, a staff member in purple scrubs entered the unit, through a door with a sign that stated all personnel entering must put on an N-95 mask, the staff member was carrying an N-95 in their hands and not wearing one; they left the unit before follow up questions could be asked. During an interview on 10/25/2024 at 5:05 PM, Director of Nursing #1 stated that staff should put on personal protective equipment before entering a covid isolation room, which should include an N-95, face shield, gloves, gown, and a surgical mask that staff change. They denied knowledge of the current Centers for Disease Control and Prevention guidance that stated N-95 masks should be discarded and replaced after caring for a resident on isolation for respiratory illness. Review of the Centers for Disease Control and Prevention guidance for Infection Control Guidance: SARS-CoV2, accessed here: https://www.cdc.gov/covid/hcp/infection-control/index.html, it documented that when an N-95 mask was used during care of a patient on droplet precautions, the N-95 mask should be removed and discarded after the patient care encounter and a new one should be donned. 10 New York Codes, Rules, and Regulations 415.19(a)(1-3)		