STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335655	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middletown Park Rehab & Health Care Center	121 Dunning Road Middletown, NY 10940

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on record review, and interviews conducted during the Abbreviated Survey (NY00371502), the facility did not ensure residents received quality of care in accordance with professional standards of practice for 1 of 3 residents reviewed. for Specifically, Resident #1 had an admission weight of 89.4lbs on 1/13/25. On 1/14/25 the resident's weight was recorded in the electronic medical record by Licensed Practical Nurse #2 as 113 pounds. Licensed Practical Nurse #2 did not notify the Physician of the significant weight gain nor request a reweigh. 2) On 1/27/2025 the Registered Dietician informed the Medical director that Resident #1's weight was 94lbs and this prompted the medical director to initiate a weight gain plan for the resident which the resident refused. 3) There was no consistent indication of how/when the weights were obtained as ordered. Weight values in the weight book were not consistently reviewed and uploaded into the Electronic Medical record by facility staff. The findings are: The 1/2024 Weight Assessment and Intervention Policy documented that the dietitian would review the weight record. Any weight change of 5% or more since the last weight would be retaken the next day for confirmation. At the discretion of the dietitian, in conjunction with the resident's presentation and team assessment, additional reweights may be requested. The dietitian would respond within 7 days upon receipt of notification of a weight change depending on the severity of the weight change. Resident #1 was admitted on [DATE] with diagnosis including but not limited to history of leukemia, and peripheral vascular disease, and transient ischemic attack. The 5-day Admission Assessment Minimum Data Set, dated dated dated [DATE] documented that Resident #1 had intact cognition, was 62 inches, 113 pounds, and had no weight loss or weight gain. The 1/13/25 Physicians Order documented that weights are to be obtained one time upon admission. The 1/13/25 Physicians Order documented that daily weights are to be done for 3 days starting the day after admission and the previous date must be entered in the comment box every day on the 7-3 pm shift every day for 3 days. Upon review of the weight monitoring of residents, it was documented that Resident #1 was weighed on 1/13/25 with a weight of 89.4 pounds and it was inactivated in the electronic medical record and could not be readily seen by all designated staff and the information was not in the nutritional assessment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335655	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middletown Park Rehab & Health Care Center	121 Dunning Road Middletown, NY 10940

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/14/25 Nutritional Status Care Plan documented that Resident #1 has a potential for altered nutritional status. Interventions included monitor weights and being reassessed as needed. The following weights were documented in the electronic health record as follows: 113 pounds on 1/14/25, 112.8 pounds on 1/15/25, 113 pounds on 1/16/25, 91.8 pounds on 1/20/25, 94 pounds on 1/27/25, and 94 pounds on 1/29/25. Review of the Dietary Progress Notes dated 1/14/25 and 1/16/25 revealed there was no documented evidence that the Registered Dietician addressed Resident #1's weight of 89.4 pounds on admission and the discrepancy in weights reported on subsequent days. Review of the Dietary Progress Notes dated 1/24/25 at 3:22 PM documented that at Care Plan meeting, resident was present with family member. The resident's intake improved, and their current weight is 113 pounds. During an interview on 4/3/25 at 9:43 am, the Registered Dietician stated that the weight sheets are put out on Fridays for the following week and that they expect the weights are to be done by Wednesday so that the weights can be discussed for the Friday meeting, and that weights are not always done on Wednesdays. The Registered Dietician stated that they do not have the specific date that the 91.8 pounds was obtained and all weights on the weight sheet should have a date of when the weight was obtained and that the Certified Nurse Aides are responsible for putting the dates. The Registered Dietician stated that they check the weights the whole week and that they would send an email to unit manager for all reweighs. The Registered Dietician stated that when Resident #1 was weighed and the weight was 91.8 pound which was significant weight loss from previous weight of 113 pounds, they were supposed to be reweighed. The Registered Dietician stated that they don't always email reweighs to the nurses and will sometimes write it on paper and give it to the nurses' aides. The Registered Dietician stated that weekly weights should be done consistently on the same day so that the weight gain or weight loss could be accurate. The Registered Dietician stated that they are not aware of the process of how the nurse checks the weights. The Registered Dietician stated that they don't normally write a progress note for a weight that needs a reweigh. The Registered Dietician stated that the reason they documented that Resident #1 was 113 pounds was because it was the only solid information that they had, and that they were not sure that the 91.8 pounds done on the week of 1/20/25 was on the weight was right because the Certified Nurse Aides don't weigh them correctly sometimes. During an interview on 4/2/25 at 4:55 Pm, the Administrator stated that going forward they will make sure weights are done the same day every week and that dates that the weight was taken will be on the documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335655	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middletown Park Rehab & Health Care Center	121 Dunning Road Middletown, NY 10940

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/3/25 at 10:13 am, Certified Nurse Aide #1 stated that the Dietician puts the weight sheet out on Friday before the weekend and that they try to do weekly weights over the weekend when they can because Monday it is busy and on Tuesdays, they are off. Certified Nurse Aide #1 stated that weights should all be done by Wednesday, and that when they get the weights, they are supposed to document it on the weight sheets and put the date obtained. Certified Nurse Aide #1 stated that there is no dates on the weight sheet and although the sheet only reflect week of, they are responsible for putting the date and their initials. Certified Nurse Aide #1 stated that they got Resident #1's weight which was 91.8 but they cannot remember the date it was obtained and forgot to put it on the weight sheet because it gets hectic. Certified Nurse [NAME] #1 stated that the previous weight is not on the weight sheets and that the Dietician, and the nurse are supposed to retrieve the weights off the weight sheet. During an interview on 4/3/25 at 12:50 PM, the Medical Director stated they are supposed to be notified of significant weight loss or gain and that all weights are supposed to have been inputted into the resident's electronic health record and was surprised that all the weights were not in there. The Medical Director stated that they were not made aware that Resident #1 had a weight of 91.8 pounds and that that nurses and the Dietician should alert them of weight loss and weight gain. The Medical Director stated that when they saw Resident #1 on 1/27/25, it was for low blood pressure, not weight loss and that it was the resident that informed them that they had history of decreased appetite, so they increased the ensure and gave them a liberalized diet (took away salt restriction). The Medical Director stated that they expect for the weight to be put in a progress note and to document if the resident requires a reweigh. The Medical Director stated that a resident that had a 19-pound weight loss requires them to be reweighed, and that the Dietician should have inputted the 91.8 lbs. into the computer the electronic health record, and that the Dietician should have placed Resident #1 on daily weights. During an interview on 4/3/25 at 1:33 PM, Registered Nurse Unit Manager #1 stated that weekly weights are expected to be done Monday and latest by noon, and that they are not in habit of checking the books and should be checking. Registered Nurse Unit Manager # 1 stated that the Certified Nurse Aides document in weight book and should be putting the date and their initial, and then they are supposed to review the weights and consult with the Dietician. Registered Nurse Unit Manager #1 stated that the Dietician is supposed to look at weights every day because there are residents who are on daily weights. During an interview on 4/3/25 at 2:55 PM, the Director of Nursing stated that the Certified Nurse Aides are supposed to document the weekly weights in the weight book/sheets along with the date taken and then initial it. The Director of Nursing stated that the unit manager is supposed to review the weights and correspond with the Dietician and have a weight meeting every Friday. The Director of Nursing stated that the expectation is that the weights are started on Sunday and done by Tuesday by 11 am. During an interview on 4/4/24 at 3:37 pm, Licensed Practical Nurse #1 stated that when Resident #1 was admitted on [DATE] during the evening shift, the certified nurse aides weighed them using the Hoyer lift and Resident #1 was 89.4 pounds and they documented it in their nursing progress note and the electronic health record, and that they report weights and vital signs to the Nursing supervisor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335655	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middletown Park Rehab & Health Care Center	121 Dunning Road Middletown, NY 10940

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/8/25 at 3:15 PM, Licensed Practical Nurse #2 stated that when a resident is admitted , the Certified Nurse Aide will way them with a Hoyer because therapy has not evaluated them and was unable to provide the name of the Certified Nurse Aide that gave them the weight of 113 pounds on 1/14/25. Licensed Practical Nurse #2 stated that after that the initial admission weight, weights are done for the next 3 days weights, but they do not look at prior weights when they input the weight into the Electronic Health Record that was given to them. Licensed Practical Nurse #2 stated that the Certified Nurse Aides should write down the weights and because if they just tell her the weights, she might forget the weight. Licensed Practical Nurse #2 stated that the order for admission weight gets deleted in the Electronic Heath Record and therefore can't see it and stated that they did their job and do not know what else to tell the surveyor. During an interview 4/8/25 at 3:30 PM, the Registered Dietician stated that the Resident #1 was 89.4 pounds on admission and that they weighed the resident for 3 days and because the nurse documented that they were 113 pounds, they assumed that the 89 pounds was incorrect. The Registered Dietician stated that although Resident #1 told them on admission that their usual body weight is under 100 pounds, they cannot believe what they say. The Registered Dietician stated that although Resident #1 appeared to be thin, they did not look like they were 89 pounds. The Registered Dietician stated that they receive the 4 day weights from the computer and that the admission weight would drop off after first day. The Registered Dietician stated that they did see that Resident #1 was weighed on admission and that it was 89 pounds, but they deactivated it because they did not think it was correct, and that they should have documented the admission weight as the first weight instead of the 113 pounds, and that the resident should have been re weighed. The Registered Dietician stated that on 1/20/25, Resident #1 had a weight of 91.8 pounds, and they did not include it in their assessment because they were waiting for reweigh which did not occur timely, therefore they documented the previous weight of 113 pounds taken on 1/16/25. The Registered Dietician stated that during the Care Plan meeting on 1/24/25, they did tell the Resident #1's family member that they were currently 113 pounds which was inaccurate because on 1/20/25, Resident #1's weight was 91.8. The Registered Dietician stated that going forward, they are going to the change weight policy and make sure the weekly weights are to be done on the same day every week, because the way the facility manages weights currently is ineffective. 10NYCRR415.12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335655	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middletown Park Rehab & Health Care Center	121 Dunning Road Middletown, NY 10940

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on record review, and interviews conducted during the Abbreviated Survey (NY00371502), the facility did not ensure that a residents' medical record contained an accurate representation and included information that accurately reflected the resident's condition, and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team for 1(Resident #1) of 3 residents reviewed. Specifically Resident #1 who was admitted on [DATE] was weighed during the evening shift and was 89.4 pounds and then weighed on 1/14/25 and was 113 pounds with inaccurate subsequent weights between 1/14-1/29/25. The Registered Dietician did not follow up on the weights recorded by the Nurses and Certified Nurses' Aides, resulting in the reporting of inaccurate weights to the medical team and the resident's representative, and causing a lack of a thorough nutritional assessment to adequately address the resident's nutritional needs. The Findings are: The Facility Policy titled Weight and Height Monitoring reviewed and revised in 2/2020 documented that the nursing staff will measure resident weights on admission, for three consecutive days, and weekly four weeks thereafter. The Dietitian will review the unit's monthly weights by the 7th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. The threshold for significant unplanned and undesired weight loss will be based on the following criteria. The Registered Dietician will run a weekly weight trend report in Sigma Care Electronic Medical record and all residents who flag for 5%; 7.5%; 10% significant weight loss will be discussed at the weekly clinical weight meeting, physician notified, and care plan interventions Resident #1 was admitted on [DATE] with diagnosis including but not limited to history of leukemia, and peripheral vascular disease, and transient ischemic attack. The 5-day Admission Assessment Minimum Data Set(MDS) dated [DATE] documented that Resident #1 had intact cognition, was 62 inches, 113 pounds, and had no weight loss or weight gain. The Resident Administration Documentation History in the Electronic Medical Record documented that at 11:25 pm, a weight of 89.4 pounds was inputted for Resident #1. The Resident Treatment Administration Record (TAR) documented that on 1/13/25 Resident #1's weight was 89.4 The weights recorded for Resident #1 were as follows: 1/29/25: 94 pounds 1/27/25: 94 pounds 1/20/25: 91.8(weight on weight sheets and not in Electronic Medical Record) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335655	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middletown Park Rehab & Health Care Center	121 Dunning Road Middletown, NY 10940

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/16/25: 113 pounds 1/15/25: 112.8 pounds 1/14/25: 113 pounds 1/13/25: 89.4 pounds The Unit 1 Working weight Sheet dated 1/20/25 documented that Resident #1 was 91.8 pounds, and the weight was not entered into the resident's Electronic Medical Record. During an interview on 4/3/25 at 9:43 am, the Registered Dietician stated that the weight sheets are put out on Fridays for the following week and that they expect the weights to be done by Wednesday so that the weights can be discussed during the Friday meeting, but the weights are not always done on Wednesdays. The Registered Dietician stated that the weight sheets are titled week of instead of indicating the dates when the weights were obtained. The Certified Nurse Aides obtain the weights any day of the week resulting in the weights not being consistent. The Registered Dietician stated that Resident #1 was on weekly weights and that they found Resident #1's weight of 91.8 pounds on the weight sheet for the week of 1/20/25 with no date making it difficult to determine when the weight was done. The Registered Dietician stated it should be that all weights taken by the Certified Nurse Aides and entered on the weight sheet should have a date of when the weight was obtained. All Certified Nurse Aides should be responsible for putting the dates for when resident weights are obtained. The Registered Dietician stated that weekly weights should be done consistently on the same day so that the weight gain or weight loss would be accurate. The Registered Dietician stated that they are not familiar with the process of how the nurse review the on the weight sheets and enter them in the electronic medical records. The Registered Dietician stated that they do not write a progress note for a weight that needs a reweigh. Residents who need reweighs are communicated verbally to the nurses. During an interview on 4/2/25 at 4:55 Pm, the Administrator stated they need a better system in place to monitor the weights and that going forward they will make sure weights are done on the same day every week and that the dates that the weights was taken are documented, and that all weights will be entered into the Electronic Health Record, and that all weight loss and weight gain will be reported to the Physician. During an interview on 4/3/25 at 12:50 PM, the Medical Director stated they are supposed to be notified of significant weight loss or gain and that all weights are supposed to be entered into the resident's electronic health record. Nurses and the Registered Dietician should alert them of weight loss and weight gain. If a resident requires a reweigh the information should be documented in the progress note. The Medical Director stated they expect that a resident with a 19-pound weight loss requires a reweigh. The Medical Director stated that they were unaware of Resident #1's weight of 91.8 pounds obtained on 1/20/25. They were only aware of the weight reported on 1/29/25 of 94 pounds. The Medical Director stated that the Dietician should have entered the weight of 91.8 pounds into the Electronic Medical Records, and the Dietician should have placed Resident #1 on daily weights. The Medical Director stated that they implemented a plan for Resident #1 to gain weight because it was reported to them that Resident #1 had a significant weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335655	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middletown Park Rehab & Health Care Center	121 Dunning Road Middletown, NY 10940

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/25 at 2:55 PM, the Director of Nursing stated that the Certified Nurse Aides are supposed to document the weekly weights in the weight book/sheets along with the date it was taken and initial their entry. The Director of Nursing stated that the unit managers are supposed to review the weights and discuss with the Dietician before the weight meeting every Fridays. The Director of Nursing stated that the expectation is that the weights are started on Sunday and done by Tuesday by 11 am, and that going forward they will put interventions into place so that the facility can monitor weights efficiently and address the Residents' nutritional needs better. During an interview 4/8/25 at 3:30 PM, the Registered Dietician stated that Resident #1 was 89.4 pounds on admission and that they weighed the resident for 3 days and because the nurse documented that they were 113 pounds, they assumed that the 89 pounds was incorrect. The Registered Dietician stated that on 1/20/25, Resident #1 had a weight of 91.8 pounds, and they did not include it in their assessment because they were waiting for reweigh which did not occur timely because the Certified Nurse Aides are difficult to ask when it's time to reweigh Residents, therefore they documented the previous weight of 113 pounds taken on 1/16/25. The Registered Dietician stated that going forward, they are going to the change weight policy and make sure that the weekly weights are to be done on the same day every week, because the way the facility manages weights currently is ineffective. 10 NYCRR 415.22(a)(1-4)