

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335655	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Middletown Park Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interviews conducted during the abbreviated survey (2644658) the facility did not ensure each resident received treatment in accordance with professional standards of practice for one (1) of three (3) residents (Resident #1) reviewed for COVID-19 infection. Specifically, an Atrovent inhaler (bronchodilator breathing medication) was not administered to Resident #1 on 10/18/2025 and 10/19/2025 as per physician order. Findings include: The facility policy titled Medication Administration: Unavailable Medication dated 11/10/2018, documented if a specific medication is not available at the prescribed time of administration, the practitioner will be notified, and new orders will be received and executed. Resident #1 had diagnoses including acute cough, asthma, and a history of COVID-19 infection. The 9/26/2025 Quarterly Minimum Data Set (a resident assessment tool) documented Resident #1 was rarely understood and did not have shortness of breath. Resident #1 was diagnosed with COVID-19 on 10/14/2025. The 10/14/2025 physician order documented Atrovent HFA (ipratropium bromide) 17 micrograms per actuation inhaler four (4) times a day at 9 AM, 1 PM, 5 PM and 9 PM. The October 2025 Medication Administration Record documented the Atrovent HFA inhaler medication was not administered as ordered on 10/18/2025 at 9:00 PM and on 10/19/2025 at 9:00 AM, 1:00 PM, and 5:00 PM. During an interview on 10/29/2025 at 9:47 AM, Licensed Practical Nurse #1 stated during report on 10/18/2025 Registered Nurse #3 told them they could not locate Resident #1's Atrovent inhaler after the 5 PM dose was administered, and that they reported it to the nursing supervisor. Licensed Practical Nurse #1 stated they re-ordered the Atrovent HFA inhaler through the medication administration system and documented the 9:00 PM dose was not administered. During an interview on 10/29/2025 at 10:07 AM, Medical Doctor #1 stated they expected to be notified if a medication was not administered for any reason. They stated they should have been notified when the Atrovent inhaler was not located for the 9:00 PM administration on 10/18/2025 and they would have given an order for a substitute medication. Medical Doctor #1 stated the nursing staff was aware they were always on call and stated they did receive calls from the facility at night. Medical Doctor #1 stated they received a call from the facility during the evening shift on 10/19/2025 and ordered a substitute medication Resident #1. During an interview on 10/29/2025 at 11:12 AM, Registered Nurse Unit Manager #2 stated the nursing staff should have notified them or a nursing supervisor when the Atrovent inhaler was missing on 10/18/2025. During an interview on 10/28/2025 at 1:40 PM, Registered Nurse #3 stated they reported to Licensed Practical Nurse #1 on 10/18/2025 that the Atrovent HFA inhaler could not be located after the 5:00 PM administration. They stated they told Licensed Practical Nurse #1 to look for the medication and if not found, they should inform the nursing supervisor. During an interview on 10/28/2025 at 2:03 PM, Registered Nurse Supervisor #4 stated on 10/19/2025 sometime after 4:00 PM, they were informed by Resident #1's family that Resident #1 did not receive the prescribed Atrovent HFA inhaler four (4) times. Registered Nurse Supervisor #4 stated they contacted the pharmacy and was told that it was too early to refill the medication. Registered Nurse Supervisor #4 stated they contacted Medical Doctor #1 by phone and received an order for Albuterol Sulfate HFA inhaler (bronchodilator breathing medication) every four (4) hours as needed. Registered Nurse Supervisor #4 stated they contacted the resident's family regarding the medication change. 10 NYCRR 415.12</p>		