STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335796	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	320 West Merrick Road Freeport, NY 11520

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on record review and interviews during survey, the facility failed to ensure that for each resident, radiological diagnostic tests were obtained in a timely fashion. This was identified for one (1) (Resident #293) of three (3) residents reviewed for hospitalization. Specifically, on 03/09/2026 Resident #293 had a physician order for a chest x-ray due to fever. There was no documented evidence that the chest x-ray was ever completed. On 03/11/2026 the resident was transferred to the hospital and was admitted with a diagnosis of pneumonia.(Complaint #2967962) The findings include:The facility's policy titled Radiologic Testing Services, dated 03/31/2021 last revised on 03/11/2026, documented the facility will provide the appropriate radiology testing required to maintain the overall health of its residents in accordance with state and federal guidelines. Radiology orders will be entered into the resident's electronic medical record and transmitted to the contracted vendor. Qualified nursing personnel will receive and review test reports and communicate results to the physician within 24 hours of receipt of results unless the report indicates results fall outside of clinical reference ranges and require immediate attention at which time the physician will be notified upon receipt of results. Documentation of the tests, the results, and date and time of physician notification will be maintained in the electronic medical record; The policy revision dated 03/11/2026 included that an audit will be conducted to ensure all orders were completed and results were obtained within 24 hours, unless the order is STAT (immediate); in that case the audit will ensure the results were obtained within eight (8) hours. The physician will be notified of any orders that do not fall within these timeframes.Resident #293 was admitted with diagnoses including cancer, hip fracture, and anxiety disorder. The 12/20/2025 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 11, indicating the resident had moderate cognitive impairment.A nursing progress note dated 03/09/2026 at 09:58 PM, written by Registered Nurse Supervisor #2, documented Resident #293 was observed in bed flushed (sweaty, reddened, warm skin), shivering, temperature 101.9 degrees Fahrenheit (normal 97 degrees Fahrenheit -99 degrees Fahrenheit), blood pressure 177/90 millimeters of mercury (normal about 120/80 millimeters of mercury), pulse 94 beats per minute (normal 60-100 beats per minute), respiratory rate 18 breaths per minute (normal 16-20 breaths per minute), and an oxygen saturation on room air 92% (normal 95%-100%). The Physician was notified and ordered blood work, urinalysis (a test to screen urine for infection and abnormalities), urine culture and sensitivity (identifies the kind of bacteria in urine and which antibiotic will be effective), and a chest x-ray.A physician's order dated 03/09/2026 at 09:55 PM documented to obtain chest x-ray (STAT0044), one time on 03/09/2026 during the 11:00 PM-07:00 AM shift for unspecified fever.A nursing progress note dated 03/10/2026 at 08:15 AM, documented the resident was receiving intravenous fluids and remained without fever throughout the night. The laboratory results were pending for chest x-ray, urinalysis, urine culture and sensitivity, and blood work.A nursing progress note dated 03/10/2026 at 08:10 PM, written by Registered Nurse Supervisor #5, documented abnormal diagnostic urinalysis results were reviewed with the Physician. The next step would be to follow up on the pending urine culture.A nursing progress note dated 03/10/2026 at 08:44 PM, written by Registered Nurse Supervisor #5, documented abnormal diagnostic blood test (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
	335796	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	320 West Merrick Road Freeport, NY 11520

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	results were reviewed with the Physician.A physician assistant note dated 03/11/2026 at 02:31 PM documented the resident was seen and examined at the bedside. Upon assessment, the resident was awake, alert, and oriented to person and place with periods of forgetfulness. The resident denied shortness of breath, chest pain, nausea, vomiting, feeling warm, chills, and dysuria (painful urination). Respiratory status was stable. The physician assistant documented that they would follow up with chest x-ray and urine culture and sensitivity results for further intervention.A review of the medical record revealed no evidence that the x-rays were obtained as per the 03/09/2026 physician's order.A nursing progress note dated 03/11/2026 at 06:57 PM, written by Registered Nurse Supervisor #3, documented that the resident was alert with confusion. The writer (Registered Nurse Supervisor #3) was called to unit by the unit nurse regarding the resident's intravenous line being dislodged. Upon arrival in the room the resident was noted shaking uncontrollably. The resident's family member was at the bedside and requested the resident to be transferred to the hospital. While the writer was assessing the resident and attempting intravenous line insertion, the resident's family called 911 (emergency service). The Physician made aware and approved the resident's transfer to the hospital for altered mental status evaluation.A nursing progress note dated 03/11/2026 at 11:58 PM documented the hospital confirmed that the resident was admitted to the hospital with a diagnosis of pneumonia.During an interview on 05/18/2026 at 11:20 AM, Registered Nurse Supervisor #2 stated they received the x-ray order for Resident #293 on 03/09/2026. They entered the order in the electronic medical record and sent the requisition to the x-ray vendor, documented the orders in the supervisor communication book in the nursing office, and called the resident's family. Registered Nurse Supervisor #2 stated that if x-ray vendor did not arrive in four (4) hours, the nurse, on the next shift, should have called the x-ray vendor again.During an interview on 05/19/2026 at 9:37 AM, the x-ray vendor representative stated they were unable to find the x-ray requisition and any evidence that the x-rays were obtained for Resident #293.During an interview on 05/19/2026 at 10:45 AM, the Director of Nursing Services stated the x-ray order on 03/09/2026 was not an actual STAT (immediate) order. The STAT0044 in the physician's order was just a communication code indicating the vendor's name (STAT). If the x-ray order was an actual STAT (immediate) order, it would be specified in the physician's order. The 03/09/2026 x-ray order was a routine x-ray order, and the x-rays should have been taken within 24 hours (on 03/10/2026) after the physician's orders. The Director of Nursing Services stated the x-ray was not done and they called the vendor on 03/10/2026 to follow up on the status. The x-ray vendor company was unable to locate the order and therefore the chest x-ray for Resident #293 was not done. The Director of Nursing Services stated they then notified Physician #1 on the evening of 03/10/2026. Physician #1 told them that a physician assistant will see the resident on 03/11/2026 to re-assess the resident and determine if the x-rays needed to be re-ordered. The Director of Nursing Services stated there were no progress notes written on 03/10/2026 regarding the communication with Physician #1 or the follow-up with the x-ray vendor company for the missed x-rays for Resident #293. The Director of Nursing Services stated Resident #293's x-rays were done timely because of a communication error between the facility and the x-ray vendor company.During an interview on 05/19/2026 at 11:30 AM, Physician #1 stated they would expect a routine x-ray to be done by the next day at least (03/10/2026) and they did not know why the ordered chest x-ray for Resident #293 was not done.During an interview on 05/19/2026 at 12:10 PM, Registered Nurse Supervisor #3 stated they worked on the 3:00 PM-11:00 PM shift on 03/11/2026. At the beginning of the shift the resident was shaking uncontrollably and had periods of confusion. Registered Nurse Supervisor #3 stated they reviewed the physician's orders and saw the chest x-rays were not done. They sent the requisition on 03/11/2026 and the x-ray technician finally came when the resident was on the stretcher heading out the door. Registered Nurse Supervisor #3 stated they did not know why the x-rays were not done prior to 03/11/2026 because when a requisition is sent the x-ray company usually responds in about 10 minutes. Registered Nurse Supervisor #3 stated that the facility staff should have documented any communication and follow up (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335796	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	320 West Merrick Road Freeport, NY 11520

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the x-ray company in the resident's medical record including the reason why the x-rays were not completed within 24 hours (on 03/10/2026).Review of the medical record revealed there was no documentation follow-up with the x-ray vendor regarding the status of the x-ray ordered on 03/09/2026.10 New York Code Rules and Regulations 415.21