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	07/29/2024

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 49245 Based on record review and interviews during the Recertification survey initiated on 7/23/2024 and completed on 7/29/2024, the facility did not ensure that all completed Minimum Data Set (MDS) assessments were electronically transmitted to the Center for Medicare and Medicaid Services (CMS) within 14 days of the resident assessment completion. This was identified for three (Residents #201, #205, and #63) of three residents reviewed for the Resident Assessment Facility Task. Specifically, Resident #201's Discharge Minimum Data Set (MDS) assessment was not electronically submitted to the Centers for Medicare and Medicaid Services (CMS) until 132 days after completion of the assessment; Resident #205's Quarterly Minimum Data Set (MDS) assessment was not electronically submitted to the Centers for Medicare and Medicaid Services (CMS) until 16 days after completion of the assessment; Resident #63's Discharge Minimum Data Set (MDS) assessment was not electronically submitted to the Centers for Medicare and Medicaid Services (CMS) until 90 days after completion of the assessment. The findings are: The facility policy titled Minimum Data Set Assessment, last revised on 10/1/2019, documented that the facility will conduct and submit a Minimum Data Set (MDS) required assessments in accordance with the Federal and State guidelines. The policy did not document the timeframe of when the assessments should be transmitted. A review of the Minimum Data Set (MDS) 3.0 Nursing Home Validation Report provided by the facility revealed the following: -Resident #201's Discharge Minimum Data Set assessment with the reference date of 3/19/2024 was submitted to the Centers for Medicare and Medicaid Services on 7/29/2024. Resident #201's Discharge Minimum Data Set transmittal was 132 days late. -Resident #205's Quarterly Minimum Data Set assessment with the reference date of 6/22/2024 was submitted to the Centers for Medicare and Medicaid Services on 7/6/2024 and was rejected. Resident #205's Quarterly Minimum Data Set was re-submitted to the Center for Medicare and Medicaid Services on 7/22/2024, Resident #205's Quarterly Minimum Data Set transmittal was 16 days late. -Resident #63's Discharge Minimum Data Set assessment with the reference date of 4/30/2024 was submitted to the Centers for Medicare and Medicaid Services on 7/29/2024. Resident #63's Discharge Minimum Data Set transmittal was 90 days late. (continued on next page)

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

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	The Director of Nursing Services was interviewed on 7/29/2024 at 1:00 PM and stated they were not aware of how the Minimum Data Set (MDS) assessments were completed and transmitted to the Center for Medicare and Medicaid Services. The Minimum Data Set Coordinators are responsible for tracking and transmitting the Minimum Data Set assessments to the Centers for Medicare and Medicaid Services. The Minimum Data Set Coordinator #1 was interviewed on 7/29/2024 at 2:00 PM and stated that Resident #201 and Resident #63's Discharge Minimum Data Set assessments were never submitted. The Minimum Data Set Coordinator #1 stated they should have checked to ensure that the Discharge and Quarterly Assessments were transmitted to the Centers for Medicare and Medicaid Services promptly. 10 NYCRR 415.11

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 7/23/2024 and completed on 7/29/2024, the facility did not ensure that an account of all controlled drugs was accurately maintained. This was identified on one (Unit 1B) of eight units. Specifically, during the medication storage task observation on Unit 1B, the Oxycodone (a narcotic pain medication) count documented in the controlled substance record did not match the amount of Oxycodone tablets present in the blister pack for Resident #407. The finding is: The facility's policy titled Management of Controlled Medications, revised 5/24/2024, documented all controlled drugs will be subject to special receipt, handling, storage, disposal, and record keeping. Controlled drug records will be maintained in such a manner as to ensure accountability, security, and ease of tracking. The medication nurse is responsible for adhering to the procedures for ordering, receiving, storing, administering, and recording the administration of controlled drugs. The medication nurse is responsible for recording any administered medications on the front of the appropriate controlled drug sheet, including the date, time, amount used, signature, and amount remaining. Resident #407 was admitted with diagnoses including Unspecified Fracture of the Left Tibia (leg bone), Hypertension, and Deep Vein Thrombosis. The 5/17/2024 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. A physician's order dated 7/23/2024 documented to administer Oxycodone 5 milligrams tablet, give one tablet by oral route every 6 hours. The diagnosis was an unspecified fracture of the upper end of the left tibia (bone in the lower leg). On 7/25/2024 at 1:12 PM during the medication storage task, on Unit 1B with Licensed Practical Nurse #1, the controlled drug record sheet for Resident #407's Oxycodone, 5 milligrams, indicated 29 tablets were remaining; however, the corresponding Oxycodone blister pack only had 28 tablets. Licensed Practical Nurse #1 was interviewed immediately after the observation on 7/25/2024 and stated they had administered a 5-milligram Oxycodone tablet to Resident #407 at 8:48 AM on 7/25/2024 and did not record the administration of the Oxycodone on the controlled drug record sheet and it was an oversight. The resident's medication administration record was signed indicating the medication (Oxycodone) was administered as ordered by the Physician. Registered Nurse #4, the Nurse Educator, was interviewed on 7/25/2024 at 1:58 PM and stated to ensure that the narcotic count matches, as soon as the medication nurse removes the controlled medication out of the blister pack, the nurse should document in the controlled drug record sheet that the medication was removed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 7/25/2024 at 2:05 PM and stated the nurses are supposed to sign the controlled drug record sheet immediately when administering a controlled substance. 10 NYCRR 415.18(b)(1)(2)(3)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on record review and interviews during the Recertification Survey initiated on 7/23/2024 and completed on 7/29/2024, the facility did not ensure that the facility assessment accurately included what resources were necessary to care for its residents competently during day-to-day operations. Specifically, the Facility Assessment incorrectly assessed the need for an excessive number of Certified Nurse Aides during the day shift (7:00 AM-3:00 PM). The finding is: The Facility assessment dated [DATE] documented the facility was assessed to have 57 Certified Nurse Aides (39 facility staff and 18 agency staff) for the day shift (7:00 AM - 3:00 PM). The Administrator was interviewed on 7/29/2024 at 1:57 PM and stated they reviewed and approved the Facility Assessment on 5/1/2024. The Administrator stated that they did not agree that the facility required 57 Certified Nurse Aides on the day shift and believed that it was a typographical error. The Administrator was re-interviewed on 7/29/2024 at 2:15 PM and stated that the number of Certified Nursing Assistants (57) in the Facility Assessment did not reflect the actual total amount of Certified Nursing Assistants required on each unit for a specific shift based on assessment of resident's need and acuity level. The Administrator stated that they should ensure the information in the Assessment was accurate and up to date when they conducted the review in May 2024. A revised Facility Assessment was provided and reviewed on 7/29/2024. The date of Assessment was unchanged. The revised Assessment documented that 39 Certified Nurse Assistants were required on the day shift (7:00 AM-3:00 PM). 10 NYCRR 415.26

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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. 41051 Based on observation, record review, and interviews during the Recertification Survey initiated on 7/23/2024 and completed on 7/29/2024 the facility did not ensure that each resident's medical record was maintained in accordance with accepted professional standards and practices. The facility did not maintain medical records for each resident that were complete and accurately documented. This was identified for one (Resident #452) of seven residents reviewed for Respiratory Care. Specifically, Resident #452 was observed receiving oxygen on 7/23/2024, 7/24/2024, and 7/25/2024 without a physician's order. The finding is: The facility policy titled, Oxygen Therapy and Monitoring dated 9/17/2019 and revised on 9/11/2023 documented that residents requiring oxygen will have oxygen ordered either as needed or continuously by the physician and/or physician extender. Resident #452 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease, Heart Failure, and Acute Kidney Failure. The Admission Minimum Data Set assessment dated , 5/22/2024 documented a Brief Interview for Mental Status score of 13, indicating the resident had an intact cognition. The Admission Minimum Data Set assessment documented Resident #452 was receiving continuous oxygen therapy upon admission. Resident #542's Comprehensive Care Plan for Respiratory Disorders/Chronic Obstructive Pulmonary Disease/Asthma, effective 5/16/2024 documented interventions to administer oxygen as ordered by the medical doctor. During an observation on 7/23/2024 at 10:30 AM Resident #452 was observed in their bed and was receiving 2 liters of oxygen per minute via a nasal cannula (a device that delivers oxygen through a tube and into your nose). Resident #452 was interviewed on 7/23/2024 at 10:30 AM and stated they were not sure how long they had been receiving oxygen. During a second observation on 7/24/2024 at 11:50 AM Resident #452 was observed in their bed. The resident was receiving 2 liters of oxygen per minute via a nasal cannula. During a subsequent observation on 7/25/2024 at 9:49 AM Resident #452 was observed in their bed. The resident was receiving 2 liters of oxygen per minute via a nasal cannula. There was no documented evidence of a current physician's order for supplemental oxygen. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #2, the medication nurse, was interviewed on 7/25/2024 at 11:38 AM and stated they provided Resident #452 with their morning medications and observed Resident #452 receiving supplemental oxygen. Licensed Practical Nurse #2 stated they did not check Resident #452's physician's orders for supplemental oxygen and did not realize there was no order in place. Licensed Practical Nurse #2 stated they would not provide medications or treatments that did not have a physician's order and they should have checked for an order. Registered Nurse #1, the Unit Manager was interviewed on 7/25/2024 at 11:50 AM and stated if supplemental oxygen was in use there should have been a current physician's order in place. The Director of Nursing Services was interviewed on 7/25/2024 at 4:44 PM and stated a physician's order should be in place if the resident was receiving oxygen therapy. 10 NYCRR 415.22(a)(1-4)