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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** Based on observations, interviews and record review during survey, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drug and biologicals) that meet the needs of each resident. This was identified for 12 (Resident #31, Resident #33, Resident #43, Resident #48, Resident #53, Resident #97, Resident #175, Resident #229, Resident #259, Resident #271, Resident #276, Resident #283) of 40 residents on Unit 3A during the Medication Storage task. Specifically, during the medication storage task observation on 05/20/2026 12 of 40 resdient's on unit 3A did not receive their medications on time, one hour before or after medication order time, as per the physician's orders. This is a repeat deficiency. The findings inlcude but were not limited to: The facility's Medication Administration policy last reviewed on 04/20/2026 documented nurses will read the medication order as stated on the Medication Administration record and will note the name, dosage, route, and time of administration to make certain the frequency and schedules correspond. Medications are to be administered in a two-hour time frame (i.e. one hour before or after medication order time). The facility's Medication-Time Schedule for Dispensing Medication policy last reviewed 06/22/2022 documented that the medication schedule for unit 3A low side (room [ROOM NUMBER]-214) are as follow: Q.D. (once a day) 8:30AMB.I.D. (twice a day) 8:30AM ; and 4:30PMT.I.D. (three times a day) 8:30AM ; 12:30PM and 4:30PMQ.I.D. (four times a day) 8:30AM ; 12:30PM, 4:30PM and 8:30PM Any times other than those specified above is at the discretion of the resident's attending physician and must be written for specific times. During the medication storage observation on unit 3A on 05/20/2026 at 11:01AM, Licensed Practical Nurse # 5 was observed administering medications to residents in the dining room. Licensed Practical Nurse # 5 stated they (Licensed Practical Nurse # 5) still have to give out morning medications to a few more residents on the unit.1) Resident #175 was admitted with diagnoses of hypertension (high blood pressure), cerebral infarction (blockage or reduced blood supply to the brain) and gastrostomy status (presence of a surgical opening in the stomach). The Quarterly Minimum Data Set assessment dated [DATE] documented that the Brief Interview for Mental Status (BIMS) score was not assessed due to resident was unable to understand. Resident #175's physician orders as of 05/20/2026 included the following medications due for 08:30 AM administration:-amlodipine 5 milligrams, give one (1) tablet by percutaneous endoscopic gastrostomy tube route (a medical device inserted directly into the stomach) once daily for hypertension.-metoprolol tartrate 25 milligrams, give half (0.5) tablet by percutaneous endoscopic gastrostomy tube route every 12 hours for hypertension.-clopidogrel 75 milligrams, give one (1) tablet by percutaneous endoscopic gastrostomy tube route once daily for cerebral infarction A review of the Medication Administration Audit Report (a report indicating medication administration time) for 05/20/2026 for Resident #175 revealed that Licensed Practical Nurse #5 documented the 8:30 AM medications were administered at 11:55 AM.2)Resident #31 was admitted with diagnoses of hypertension (high blood pressure), peripheral vascular disease (reduced circulation of blood in a body part that is not the brain or the heart) and myocardial infarction (blockage or reduced blood supply to (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	the heart muscle). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score was not assessed due to resident was unable to understand. Resident #31's physician orders as of 5/20/2026 included but are not limited to the following medications due for 8:30 AM administration:-metoprolol tartrate 100 milligrams, give one (1) tablet by gastrostomy tube (G-tube) route (a medical device inserted directly into the stomach) two (2) times per day for hypertension.-clopidogrel 75 milligrams, give one (1) tablet by gastrostomy tube (G-tube) route (a medical device inserted directly into the stomach) once daily for peripheral vascular disease.A review of the Medication Administration Audit Report (a report indicating medication administration time) for 05/20/2026 for Resident #31 revealed that Licensed Practical Nurse #5 documented the 8:30 AM medications were administered at 11:47 AM.3) Resident #271 was admitted with diagnoses of type 1 diabetes metllitus (non insulin dependent) with hypoglycemia, hypertension (high blood pressure), and polyneuropathy (malfunction of peripheral nerves throughout the body). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of six (6) which indicated severely impaired cognition. Resident #271 received hypoglycemic medication but no insulin injections was ordered or administered in the look-back period. Resident #271's physician orders as of 5/20/2026 included but are not limited to the following medications due for 8:30 AM administration:-janumet 50 milligrams -1000 milligrams (combination of two hypoglycemic medications), give one (1) tablet by oral route two (2) times per day for diabetes mellitus.-jardiance 25 milligrams, give one (1) tablet by oral route once daily for type 1 diabetes mellitus with hypoglycemia. A review of the Medication Administration Audit Report (a report indicating medication administration time) for 05/20/2026 for Resident #271 revealed that Licensed Practical Nurse #5 documented the 8:30 AM medications were administered at 11:37 AM.During an interview on 05/20/2026 at 11:51AM, the Director of Nursing Services stated that all medications should be administered within a two-hour timeframe of the medication order time. The Director of Nursing Services stated that 08:30 AM medication should be administered between 07:30 AM to 09:30AM. The Director of Nursing Services stated that medication nurses should notify the unit manager if they have difficulty completing the task on their own. The Director of Nursing Services stated they expected the unit manager to assist in administering medications to the residents and that theresident should not received their medications late. During an interview on 05/20/2026 at 01:06 PM, Licensed Practical Nurse #5, the medication nurse on Unit 3A, stated that they were not regularly assigned to unit 3A and were late in medication administration this morning because they were not familiar with the residents and were adjusting to the new workload. Licensed Practical Nurse # 5 stated they notified the unit manager, Registered Nurse # 7, that they required assistance; however, Registered Nurse # 7 was unable to assist them until residents' treatments were completed. Licensed Practical Nurse # 5 stated they were administering all the medications on their own until around 11:00AM. During an interview on 05/20/2026 at 01:17 PM, Registered Nurse #7, the unit manager, stated Licensed Practical Nurse #5 asked for assistance with medication pass shortly before 11:00 AM. Registered Nurse #7 stated they did not know that at that time there were 12 residents who still needed to receive their morning medications. Registered Nurse #7 stated that they did not assist Licensed Practical Nurse #5 in medication pass because they were administering scheduled morning treatments to the residents. Registered Nurse #7 stated medication nurse is typically responsible for giving out medications and completing treatments and they were assisting Licensed Practical Nurse #5 by doing the treatments. During an interview on 05/20/2026 at 01:43 PM, Physician #1, who is also the Associate Medical Director, stated the residents should receive the physician ordered medications within one (1) hour before or one (1) hour after the timeframe specified in the physician's orders. Physician #1 stated and the facility worked closely with pharmacy to reduce unnecessary medication. Associate Medical Director stated extra help should also be considered to ensure medications are administered to residents in a timely manner. During an interview on 05/20/2026 at 02:19 PM, the Medical Director stated stated if the nurses are late in administering (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	medications, they should ask for help. Generally, the nurses should administer medication within one (1) hour before or one (1) hour after the physician-ordered administration time. 10 New York Code Rules and Regulations 415.18(a)

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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 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** Based on observation, record review, and interviews during the survey, the facility failed to ensure it provided an infection control program designed to help prevent the development and transmission of communicable diseases for two (Resident #140 and #125) of five residents observed during medication administration and for one (1) (Resident #193) of ten (10) residents reviewed for infection control task. Specifically, during the medication administration observation on 05/14/2026, 1) Licensed Practical Nurse #3 wore gloves to fill an irrigation kit bottle with tap water from the bathroom sink and then went to the bedside of Resident #140 to flush the gastrostomy tube without changing gloves or sanitizing hands; 2) Licensed Practical Nurse #4 used bare hands to break a potassium chloride table in half at the request of Resident #125 because the table was too large to swallow; and 3) Resident #193 had a physician's order to maintain contact precautions for colonization of multi drug resistant organisms in the urine and chronic wounds on the lower extremities. On 05/13/2026, Certified Nursing Assistant #3 was observed entering Resident #193's room without applying appropriate personal protective equipment. The findings include: The facility policy titled Medication Administration, revised 05/30/2025, does not address hand washing/hand sanitizing or changing gloves during the medication administration process. The policy does not state that medication tablets should not be handled with bare hands. A facility policy titled Infection Control-Transmission Based Precautions last revised 05/01/2025 documented the facility utilizes transmission-based precautions in with standard precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. The use of transmission-based precautions, special instructions and any restrictions on activities which may be imposed are to be explained to all staff involved and the residents or their representatives. Appropriate signage will be posted on the resident's door. Appropriate personal protective equipment will be donned (put on) upon entry into the environment of a resident on transmission-based precautions since the nature of the interaction with the resident cannot be predicted with certainty and contaminated environmental surfaces ae important source for transmission of pathogens. 1) Resident #140 was admitted with diagnoses including cerebrovascular accident, gastrostomy (a small opening in the abdominal wall directly into the stomach to place a feeding tube (gastrostomy tube), and respiratory failure. The 02/14/2026 quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 5, indicating the resident had severe cognitive impairment. The Minimum Data Set indicated the resident had a feeding tube. A physician's order dated 03/02/2026 and renewed on 05/01/2026 documented gastrostomy tube, size 22 French, balloon size 20 cubic centimeters. A physician's order dated 04/17/2026 and renewed on 05/01/2026 documented tube feeding, Jevity 1.5 to run at 80 milliliters per hour for 15 hours for a total of 1,200 milliliters. Flush gastrostomy tube with 30 milliliters of water before and after each full medication administration. Each individualized medication is to be diluted in 10-15 milliliters of water. Flush gastrostomy tube with 10 milliliters of water after each individual medication is administered. (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 on 05/14/2026 at 8:32 AM, Licensed Practical Nurse #3 prepared Resident # 140's physician ordered medications for administration. Licensed Practical Nurse #3 put on personal protective equipment (gown and gloves) as the resident was on enhanced barrier precautions and proceeded to the resident's bedside with the medications. While wearing the gloves, Licensed Practical Nurse #3 took the irrigation bottle that was hanging in a plastic bag at the resident's bedside and brought it into the resident bathroom to fill with tap water; using the same gloves the nurse handled the sink faucets and rinsed out the bottle and filled the bottle with water. Licensed Practical Nurse #3 did not change gloves or sanitize their hands and went back to the resident's bedside. Using the same gloves, Licensed Practical Nurse #3 picked up the syringe and was about to flush the gastrostomy tube when the surveyor pointed out that the nurse had not changed gloves or sanitized hands after handling the bathroom sink faucets. Licensed Practical Nurse #3 stated they should have removed their gloves and sanitized hands and proceeded to wash their hands. During an interview on 05/18/2026 at 9:45 AM, the Registered Nurse Infection Preventionist stated this not washing hands created a potential infection control breach because the sink faucets are dirty. Licensed Practical Nurse #3 should have removed gloves and sanitized hands before handling any resident equipment or attempting to flush the gastrostomy tube. During an interview on 05/19/2026 at 1:00 PM, the Director of Nursing Services stated the nurses must follow the infection control protocols such as washing hands, changing gloves, and preparing the medications before entering the residents' room. 2) Resident #125 was admitted with diagnoses including hip fracture, congestive heart failure, and hypertension. The 04/09/2026 5-day Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. During the medication pass administration observation on 05/14/2026 at 9:03 AM, Licensed Practical Nurse #4 prepared the following physician-ordered medications at the medication cart outside the resident's room by placing each medication in a souffle cup: Amiodarone 200 milligram tablet (for prevention of dangerous irregular heart rhythms). Amlodipine 5 milligram-atorvastatin 10 milligram tablet (treats high blood pressure and high cholesterol). Gabapentin 300 milligram capsule (treats nerve pain). Hydroxychloroquine 200 milligram tablet (treats rheumatoid arthritis). Multiple Vitamin-Minerals tablet (supplement). Potassium chloride 20 milliequivalent (supplement for low potassium levels); and Torsemide 20 milligram tablet (treats excessive fluid in body). Physician's orders documented that Resident #125 received regular food consistency and thin liquids, indicating there were no swallowing concerns. Licensed Practical Nurse #4 brought the prepared medications to the bedside. During the process of administering the medications, the resident handled the potassium chloride tablet and stated they wanted the tablet cut in half to ease swallowing. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident handed the tablet back to the nurse. Licensed Practical Nurse #4 brought the tablet back to the medication cart and discarded the tablet; the nurse sanitized their hands and then popped another potassium chloride tablet from the blister pack using bare hands and then broke that tablet in half and placed the two-halved tablets in a souffle cup to administer the medications to the resident. Upon questioning, Licensed Practical Nurse #4 stated it was not appropriate to touch the tablets with bare hands and that they should have used gloves. Licensed Practical Nurse #4 then discarded the potassium chloride tablet that they just broke in half, put on a pair of gloves, and popped a new tablet to administer to the resident. During an interview on 05/18/2026 at 9:45 AM, the Registered Nurse Infection Preventionist stated the nurse should have worn gloves to handle the medication and not bare hands. During an interview on 05/19/2026 at 10:15 AM, the Assistant Director of Nursing Services, responsible for nursing education, stated the nurse should have used gloves, or had the potassium chloride tablet order changed to the liquid form; the nurse did not meet the infection control protocol by handling a medication with bare hands. During an interview on 05/19/2026 at 1:00 PM, the Director of Nursing Services stated the nurses must follow the infection control protocols, washing hands, and changing gloves. follow the protocol, follow the training. The nurses are not supposed to handle medications with bare hands. 3) Resident #193 was admitted with diagnoses including methicillin susceptible staphylococcus aureus infection, resistance to carbapenem, chronic venous hypertension with ulcer of the right and left lower extremity. A Significant Change in Status assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented that the resident had two (2) venous and arterial ulcers present, and the resident had frequent urinary incontinence. A comprehensive care plan titled Contact Precautions initiated 02/09/2026 and last revised on 02/11/2026 documented interventions to educate the resident, family, and staff on contact precautions; alert the physician of any signs and symptoms of inability to contain infection and report any changes in the resident's condition to the Physician. A physician's order initiated 03/03/2026 and renewed on 05/06/2026 documented to maintain contact precautions secondary to colonization of carbapenem resistant Enterobacterales (bacteria) in the urine and methicillin resistant staphylococcus (bacteria) in the wounds (lower extremities). During an observation on 05/13/2026 at 12:54 PM, a sign was observed posted outside the resident's door that documented Contact Precautions: everyone must clean their hands, including before entering the and when leaving the room. Providers and staff must also put on gloves and gown before room entry and before room exit. Certified Nursing Assistant #3 was observed entering Resident #193's room with a meal tray. Certified Nursing Assistant #3 did not have any personal protective equipment as per the signage. Certified Nursing Assistant #3 placed the meal tray on the resident's bedside table and adjusted the resident's water pitcher and other items on the bedside table. Certified Nursing Assistant #3 then stepped outside the resident's room, performed hand hygiene and applied a gown and gloves from a bin that was placed outside the resident's room and went back into the resident's room. During an interview on 05/13/2026 at 1:03 PM, Certified Nursing Assistant #3 stated they did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have to apply personal protective equipment to bring a meal tray for the resident. Certified Nursing Assistant #3 stated the resident then wanted assistance with repositioning in bed and that is when they (Certified Nursing Assistant #3) on the personal protective equipment because at this time they were going to provide direct care to the resident. During an interview on 05/13/2026 at 1:27 PM, Registered Nurse #6, the unit manager, stated Resident #193 had a physician's order for contact precautions and Certified Nursing Assistant #3 should have put on appropriate personal protective equipment prior to entering the resident's room and must remove them prior to exiting the resident's room no matter the circumstance. During an interview on 05/15/2026 at 2:31 PM, the Infection Preventionist stated Resident #193 was on contact precautions because of multidrug resistant organism infection in the urine and the wounds. Prior to entering the resident's room Certified Nursing Assistant #3 should have applied a gown and gloves, as per the signage posted outside the resident's room. During an interview on 05/19/2026 at 2:31 PM, the Director of Nursing Services stated Certified Nursing Assistant #3 should have applied gown and gloves prior to entering Resident #193's room for every instance they enter the resident's room because the resident was on contact precautions. 10 New York Code Rules and Regulations 415.19(b)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to ensure that all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles. This was identified for two (2) (Resident #5 and Resident #13) of four (4) residents reviewed for accidents. Specifically, 1) Resident #5 was observed with an unlabeled bottle of Tums (antacid medication to relieve heartburn and acid indigestion) on their overbed table. Resident #5 did not have a physician's order for the use of Tums or a self-administration assessment. There was no Nursing staff within the vicinity of Resident #5's room. 2) Resident #13 was observed with a labeled clotrimazole cream (an antifungal cream) one (1) percent on their overbed table. There were no nursing staff within the vicinity of Resident #13. Resident #13 did not have a self-administration assessment or a physician's order to self-administer the medications including the antifungal cream.The findings include:The facility's policy titled Medication Storage and Handling, last revised on 09/19/2025, documented that the Unit Nurse will assure that all resident medications are to be properly labeled, stored, and locked securely in the medication room or medication cart. All drugs and biologicals are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys.1)Resident #5 was admitted with diagnoses including atrial fibrillation (irregular heart rhythm), gastroesophageal reflux disease (stomach acid repeatedly flows back into the esophagus) and diabetes mellitus (high blood sugar). The annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated that Resident #5 had moderate cognitive impairment. The annual Minimum Data Set assessment documented an active diagnosis of gastroesophageal reflux disease. A Comprehensive Care Plan (CCP) titled, Abdominal Discomfort, dated 05/18/2026 documented interventions including medications as ordered by the Physician, observation for decreased appetite, nausea, vomiting, complaints of gastric pain and evaluation of effectiveness of medication. A review of Resident #5's electronic medical record revealed that Resident #5 did not have a physician's order for Tums.A review of Resident #5's electronic medical record revealed that Resident #5 did not have a self-administration assessment or a physician's order to self-administer medications. During an observation on 05/14/2026 at 9:28 AM, Resident #5 was lying in bed. A bottle of unlabeled Tums was observed on the overbed table. There was no nurse within the vicinity of Resident #5's room.2) Resident #13 was admitted with diagnoses including chronic obstructive pulmonary disease (progressive lung disease that makes breathing hard), diabetes (high blood sugar) and rash (an area of inflamed, swollen or irritated skin). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated that Resident #13 had moderate cognitive impairment. The Minimum Data Set documented that Resident #13 did not have an open lesion (localized area of abnormal tissue damage) other than ulcers (open sore), rashes, and cuts. A physician's order dated 05/11/2026 documented Lotrimin (antifungal) one percent cream, apply topically to the right posterior (back) upper arm twice a day for fourteen (14) days. A Comprehensive Care Plan (CCP) titled, Skin Integrity: Rash dated 05/11/2026 documented interventions including medication and treatment as ordered by the Physician and observation of effectiveness of prescribed treatment and medication. A review of Resident #13's electronic medical record revealed that Resident #5 did not have a documented assessment or a physician's order to self-administer the medication.During an observation on 05/14/2026 at 9:26 AM, Resident #13 was observed lying in bed. A labeled Lotrimin cream one percent was on the overbed table. There was no nurse within the vicinity of Resident #13's room.During an interview on 05/14/2026 at 9:30 AM, Licensed Practical Nurse #1, the medication nurse, stated that they did not notice the bottle of Tums on Resident #5's (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	overbed table. Licensed Practical Nurse #1 stated that the bottle of Tums was unlabeled and did not come from the facility. Licensed Practical Nurse #1 stated that the Lotrimin cream for Resident #13 must have been left by the nurse from the previous shift. Licensed Practical Nurse #1stated they did not give the antifungal cream tube to Resident #13. Licensed Practical Nurse #1 stated that Resident #5 and Resident #13's medications are administered by the nurses at the facility. Licensed Practical Nurse #1 stated that all medications should be locked in the medication cart after administration. During an interview on 05/14/2026 at 9:33 AM, Registered Nurse #1, the unit manager, stated that all medications should be locked in the medication cart after administration. Registered Nurse #1 stated that Resident #5 and Resident #13 did not have any assessment to self-administer their medication because they (Resident #5 and Resident #13) needed assistance from a nurse to administer their medication. During an interview on 05/15/2026 at 8:52 AM, Licensed Practical Nurse #2, Medication Nurse for 3:00-11:00 PM shift, stated they applied the antifungal cream on Resident #13's upper arm on their shift (3:00-11:00 PM) and was called by another resident. Licensed Practical Nurse #2 stated they forgot to take the antifungal cream from Resident #13's room and the medication was left on the resident's overbed table. Licensed Practical Nurse #2 stated they forgot to lock the antifungal cream in their medication cart. During an interview on 05/18/2026 at 2:39 PM, the Director of Nursing Services stated that nurses should follow the medication administration and storage policy which include locking the medication in the medication cart after administration. The Director of Nursing Services stated that all nursing staff should be checking and reporting any medications left in resident's room.10 New York Code Rules and Regulations 415.18(e) (1-4)