

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Harlem Ctr for Nursing and Rehabilitation, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 30 West 138th Street New York, NY 10037	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the Abbreviated Survey (Complaint #2634618) the facility failed to ensure that one (1) (Resident #1) of three (3) residents reviewed for quality of care, received treatment and care in accordance with professional standards of practice. Specifically, an order for comprehensive metabolic panel and complete blood count was made for Resident #1 but was not carried out. There was no documentation available in the medical record to explain why the test was not completed. The findings include: The undated facility policy titled Physician Services documented the resident's Attending Physician is responsible for prescribing new therapy, ordering a transfer to the hospital, conducting required routine visits, delegating and supervising follow-up visits from Nurse Practitioners or Physician Assistants, etc., to ensure that the resident receives quality care and medical treatments. Resident #1 had diagnoses of Diabetes Mellitus, Hypertension, and Urinary Tract Infection. The admission Minimum Data Set assessment dated [DATE] documented that Resident #1 had moderately impaired cognition. A nurse's progress note dated 09/20/2025 at 3:22 PM documented the registered nurse was called to assess Resident #2 with complaints of headache, abdominal pain, and chest pain. The note documented that telehealth was consulted and that they spoke with the nurse practitioner who ordered chest x-ray, comprehensive metabolic panel, and complete blood count. A physician's order dated 09/20/2025 documented Comprehensive Metabolic Panel and Complete Blood Count with Auto Differential one time only related to Chest pain, stat (immediately). A telehealth notes by Nurse Practitioner #1 dated 9/20/2025 at 2:52 PM documented Resident #1 reported having headache, mild chest pain, and abdominal pain. The resident's last bowel movement was yesterday, and the resident was not passing gas. Orders were placed for laboratory and imaging to evaluate for infection, constipation, or other abdominal process. Comprehensive metabolic panel and complete blood count were ordered to assess metabolic and infectious status. There was no documented evidence in Resident #1's medical record that the complete blood count and comprehensive metabolic panel were drawn. There was no documentation available in the medical record to explain why the tests were not completed. A progress note by Physician #1 dated 09/22/2025 documented that Resident #2 was seen and examined for abnormal urine. There was no documentation in the progress note stating that comprehensive metabolic panel and complete blood count were no longer necessary. On 10/24/2025 at 12:20 PM, Registered Nurse #2 who was the nursing supervisor, was interviewed and stated they do not recall Resident #1's stat labs that were ordered on 09/20/2025. Registered Nurse #2 stated they cannot explain what happened and why the blood work was not done and followed up. On 10/22/2025 at 2:35 PM, Physician #1 was interviewed and stated the telehealth note on 09/20/2025 was from a weekend on call provider. Resident #1 was having headaches and abdominal pain. The note documented on their plan that they wanted to do a chest x-ray and blood work. Physician #1 stated that the chest x-ray was completed, and a urine sample was obtained to rule out an infection. Physician #1 stated they do not think that blood work was necessary when they returned to work on Monday, 09/22/2025, since the findings from 09/20/2025 confirmed a urinary tract infection which explained Resident #1's symptoms. On 10/24/2025 at 1:47 PM, the Director of Nursing was interviewed and stated they think that the order was not completed because the resident refused blood drawing. The Director stated that if a laboratory order was not completed, the reason should be documented in the medical record. On 10/24/2025 at 11:16 AM, the Medical Director was interviewed and stated when the primary physician comes back in after the weekend, they follow up on any telemedicine orders and either continues the orders or makes necessary changes based on the physical assessment of the resident. Any critical issues that occurred over the weekend that need attention are communicated on the dashboard for the physician to review on Monday. In an ideal situation progress notes should document why the laboratory work was not done. On 10/24/2025 at 2:12 PM, the Administrator was interviewed and stated if a resident refuses to have their blood drawn, the laboratory technician would communicate this with nursing. On Mondays, physicians should review the dashboard and follow up and agree or not agree with the telehealth orders. The Administrator stated they believe the laboratory technician came because the confirmation number is in the progress notes. It could have been that Resident #1 refused to have their blood drawn, stating that Resident #1 had history of refusals. The Administrator also stated that if a resident refused blood draw, the nurse should have communicated this with the physician and documented in the medical record. 10 NYCRR 415.12</p>		