STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335792	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Manhattan Rehabilitation and Nursing Ctr	116 East 125th St New York, NY 10035

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and interviews conducted during an Abbreviated survey (6220995), the facility did not ensure a resident was free from abuse. This was evident for one (1) of four (4) residents (Resident #7) sampled. Specifically, on 03/05/2025 at 6:30 PM, Resident #7 reported to Licensed Practical Nurse #1 that they were hit with a bottle on their upper lip by Certified Nursing Assistant #9. Resident #7 was assessed by the Director of Nursing on 03/05/2025 and was observed with slight swelling to their upper lip. The findings are:The policy and procedure on Abuse dated 02/2025 stated each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, and involuntary seclusion. It is the responsibility of the employees, facility consultants, attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. Resident #7 was admitted to the facility with diagnoses including Hypertension and Anxiety Disorder.The Minimum Data Set (an assessment tool) dated 06/18/2024 documented Resident #7 had moderately impaired cognition. A potential for abuse/neglect/misappropriation/exploitation care plan dated 01/29/2025 documented interventions which included to provide 1:1 visit and encourage the resident to socialize and participate in recreational activities.A Nursing Note by the Director of Nursing dated 03/05/2025 at 9:09 PM, documented at approximately 6:30 PM Resident #7 alleged Certified Nursing Assistant #9 threw an Ensure (a liquid supplement) bottle at their lips. Physical assessment revealed slight swelling. There was no bruising or bleeding observed. An ice pack was applied to the lips. Certified Nursing Assistant #9 denied the allegation. Emergency personnel arrived on the unit, but did not provide a report. Resident #7 was placed on 15 minutes monitoring for three (3) days and was referred for psychiatric and psychological evaluation. The facility's investigation dated 03/05/2025 documented Resident #7 reported Certified Nursing Assistant #9 made physical contact with their upper lip using an Ensure bottle. Upon examination, the resident had slight swelling to their right upper lip. Certified Nursing Assistant #9 denied the allegation. The resident could not recall the location of the Ensure bottle and a bottle was not found in the resident's area, therefore the facility concluded there were no evidence of abuse, neglect, or mistreatment. A Medical Note by Medical Doctor #1 dated 03/07/2025 at 3:36 PM documented Resident #7 was evaluated and reiterated they asked Certified Nursing Assistant #9 to help them with something and Certified Nursing Assistant #9 grew angry at them and threw a bottle of Ensure at them. An assessment revealed a bruise to the upper midsection of the lip, and inside the lip was black and blue. A new black and blue area was noted this morning (03/07/2025) inside the edge of the left lower lip area with bruising extending underneath. During an interview on 07/08/2025 at 11:51 AM, Resident #7 stated Certified Nursing Assistant #9 hit them with a soft bottle on their lip. Resident #7 was unsure of date and time.Several unsuccessful attempts were made to contact Certified Nursing Assistant #9. A certified letter was mailed on 07/28/2025 with no response as of today. Certified Nursing Assistant #9 provided a statement to the facility dated 03/05/2025. The statement documented they went into Resident #7's room at around 6:15 PM on 03/05/2025 to turn on their heater and then left. The resident did not verbalize any complaints and was stable. The resident's family was visiting and approached them in an aggressive and threatening manner at 6:30 PM and accused them of abuse. The statement further documented they did not abuse the resident.During a telephone interview on 07/28/2025 at 12:46 PM, Certified Nursing Assistant #10 stated at approximately 5:58 PM they responded to Resident #7's call bell and observed Resident #7 tapping and pointing at their mouth. Certified Nursing Assistant #10 stated Resident #7 reported they were hit on their lip. Certified Nursing Assistant #10 stated Certified Nursing Assistant #9 was standing in the doorway at Resident #7's room and reported Resident #7 hit them with a bottle, and they threw the bottle at Resident #7. Certified Nursing Assistant #10 stated they did not see an Ensure bottle, but a juice bottle was next to Resident #7's bed. Certified Nursing Assistant #10 stated Resident #7's lip was swollen at the top, but they did not see any redness. Certified Nursing Assistant #10 stated Registered Nurse Supervisor #2 had all staff members in Resident #7's room and the resident identified Certified Nursing Assistant #9 as the staff who hit them with the bottle. During a telephone interview on 07/28/2025 at 2:27 PM, Licensed Practical Nurse #1 stated Registered Nurse Supervisor #2 arrived on the unit at 6:30 PM and went to Resident #7's room. Licensed Practical Nurse #1 also stated Resident #7 reported Certified Nursing Assistant #9 hit them with an Ensure bottle. Licensed Practical Nurse #1 further stated they looked in the room and did not see any Ensure bottles but saw other bottles in

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated survey (622104), the facility did not ensure that a resident care plan was reviewed and revised by the interdisciplinary team. This was evident for one (1) out of seven (8) residents sampled (Resident #4). Specifically, Resident #4 reported to Certified Nursing Assistant #3 that they had pain in their left arm on 03/27/2025, just before lunch, and Registered Nurse #4 was notified. Resident #4 complained of pain their left arm again on 03/28/2025 and the left arm was observed to be swollen and larger than the right. Registered Nurse #4 notified Physician #1 who ordered Tylenol (1000 milligrams) and a STAT x-ray. Resident #4 was transferred to the hospital on [DATE] with Altered Mental Status, a blood pressure of 184/110, pulse 110, and to rule out Deep Vein Thrombosis (a blood clot forming in the deep vein). Resident #4 was diagnosed with a fracture of the left proximal humerus in the hospital. There was no documented evidence the care plans were updated to reflect on Resident #4's pain and changes in condition. Findings are:The Policy titled Comprehensive Assessment and Comprehensive Care Planning Process last reviewed 10/2023 documented the interdisciplinary comprehensive care planning team will function to ensure that each resident has a care plan that identifies the physical, social, nutritional, environmental, recreational, spiritual and rehabilitative aspects of care with immediate and long-term care goals as well as a discharge plan. Each individualized comprehensive care plan will identify resident's needs as well as approaches to care and methods for provision of care. Resident #4 was last admitted to the facility 08/14/2024 with diagnoses including Cerebrovascular Accident (Stroke) with hemiplegia and Dementia. The Minimum Data Set (a resident assessment tool) dated 01/02/2025 documented Resident #4 had mentally impaired cognition. Primary language Creole.A Pain Management Care Plan was created 10/9/2024 and last updated 01/04/2025. Documentation reveals a quarterly evaluation, and that the resident was stable and verbalized no complaints of pain. Also states that pain medication will be administered as needed per order. Also documented is that monitoring will continue x 90 days. A Nursing Note by Registered Nurse #4 dated 03/31/2025 (late entry for 03/28/2025) documented Resident #4 had a swollen left arm that was larger than the right and complained of pain. Temperature 98.2, Pulse 82, Respiration 18, and Blood Pressure 132/78. Physician #1 was notified via telephone and ordered an x-ray of the left arm and Tylenol 1000 milligrams times one received. Also documented, a verbal report was given to oncoming Licensed Practical Nurse #3 (day shift) of the physician's order for x-ray and Tylenol. The Facility Investigative Summary dated 03/31/2025 documented Resident #4 reported that they had pain in their left arm. The nurse in charge assessed the area and administered Tylenol, which provided temporary relief. On 03/28/2025 staff observed slight swelling of the left upper arm with continued reports of mild pain. The physician was notified, and an x-ray was ordered, and pain management was adjusted. On 03/31/2025 Resident #4's swelling had increased, and the affected area was noted to be warm to the touch. The resident also began to exhibit altered mental status. Physician #2 evaluated the resident and ordered hospital transfer to rule out Deep Vein Thrombosis and assess mental status change. On 04/01/2025 during a follow up with the hospital, they reported Resident #4 had a left proximal humerus fracture. The report did not indicate if the fracture was acute or chronic. The investigation concluded there was no evidence to suggest abuse, neglect, or staff misconduct in relations to the resident's left proximal humerus fracture. A late entry note dated 04/14/2025 (for 03/28/2025) by Physician #1 documented they were contacted by nursing on 03/28/2025 at 3:50 PM regarding Resident #4's pain and swelling to the left upper arm with activity. No trauma was reported. A STAT upper arm x-ray and Tylenol 1000 milligrams times one dose was ordered and physician to be called with the results and change in condition. The primary floor attending to be informed. There was no documented evidence the relevant care plans were reviewed and revised to reflect on Resident #4's changes in condition. During a telephone interview on 08/08/2025 at 3:28 PM, the Assistant Director of Nursing stated the care plans are updated when there's a change in condition. They stated that the Registered Nurses are responsible for updating the care plans. The Assistant Director of Nursing stated that if a resident is complaining of pain, the physician should be informed, pain medication should be ordered, and the relevant care plans should be updated with monitoring. During a telephone interview on 08/08/2025 at 3:11 PM, Registered Nurse Supervisor #2 stated that the Registered Nurses and Registered Nurse Supervisors are responsible for updating the care plans if there is a change in condition. They stated they were not aware of Resident #4's complaint of pain. 10 NYCRR 415.12

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated survey (622104 & 662084), the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. This was evident for two (2) of seven (7) residents (Residents #4 and #5) sampled. Specifically: 1. Resident #4 complained of pain to their left arm on 03/27/2025 and 03/28/2025. There was no documented evidence medical interventions were completed. On 03/31/2025, Resident #4 was transferred to the hospital with altered mental status and to rule out deep vein thrombosis (a blood clot forming in the deep vein). At the hospital, Resident #4 was diagnosed with a fracture of the left proximal humerus. This resulted in actual harm to Resident #4 that was not Immediate Jeopardy. 2. Resident #5 complained of pain to their right hip on 09/17/2024 and a STAT x-ray was ordered by Physician #3 on 09/18/2025. Resident #5 was transferred to the hospital on [DATE] at 9:11 AM and was diagnosed with a fracture to their left hip. There was no documented evidence a physical assessment was done to ascertain the source of the pain, or that a physician was notified on 09/17/2024. A STAT x-ray was not ordered and was not done in the facility. The findings include:The policy titled 'Pain Assessment', last reviewed 10/2005, states every resident will be assessed on admission for pain management and thereafter as medically indicated. Respectively, pain control measures should be used before pain becomes severe. It also states to notify the physician if measures are unsuccessful or if current complaint is a significant change from the resident's experience. The policy titled 'Change in Resident's Condition', last reviewed 03/2022, documented it is the policy of Northern Manhattan Nursing Home to document any change in a resident's condition and to inform the Medical Doctor and designated representative in a timely fashion. The policy also documented that the resident is placed on the 24-hour report and care is rendered according to need and Medical Doctor order. The facility policy and procedure titled 'Diagnostic Services and Guidelines', dated 11/2023, documented upon a physician's order for diagnostic tests, the nursing department will arrange for the specimen to be obtained or tests to be done as per nursing policies and procedures, on a schedule basis or immediately, if the order is for stat (immediately or without delay) tests. Resident #4 was last admitted to the facility 08/14/2024 with diagnoses including cerebrovascular accident (stroke) with hemiplegia (paralysis to one side of the body) and dementia. The Minimum Data Set (a resident assessment tool) dated 01/02/2025 documented Resident #4 had mentally impaired cognition. Primary language Creole.A Nursing Note by Registered Nurse #4, dated 03/31/2025 at 1:47 PM indicated that it was a late entry for 03/28/2025 at 3:20 PM. It documented that Resident #4 had a swollen left arm that was larger than the right and complained of pain. Temperature 98.2, pulse 82, respiration 18, and blood pressure 132/78. Physician #1 was notified via telephone and ordered an x-ray of the left arm and Acetaminophen 1000 milligrams times one (1) received. The note documented a verbal report was given to Licensed Practical Nurse #3 (day shift) of Resident #4's clinical condition and the physician's order for x-ray and Acetaminophen times one (1) dose. There was no documented evidence that Registered Nurse #4 conducted a pain assessment or verified that pain medication was administered to the resident. There was no documented evidence that Registered Nurse #4 informed Licensed Practcial Nurse #3 of the order for an x-ray. A Nursing Note by the Assistant Director of Nursing dated 03/31/2025 at 7:04 PM, documented that they were called by Registered Nurse Supervisor #1 to evaluate Resident #4. Resident #4's left upper extremity was swollen especially around the left shoulder extending to the resident's neck and left face. There was no bruising noted, and no falls were reported by staff. A Transfer Summary Note by Registered Nurse #1 dated 03/31/2025 at 1:28 PM, documented Resident #4 was being transferred to the hospital to rule out deep vein thrombosis (a blood clot forming in the deep vein) to their left upper extremity and altered mental status. Resident #4's blood pressure was 184/110 and pulse 110.A Nursing Note by Licensed Practical Nurse #6 dated 03/31/2025 documented Resident #4 left for the hospital at 1:55 PM. There was no documented evidence Resident #4 was placed on the 24-hour report from 03/27/2025 - 03/29/2024. A Physician Order Activity Detail Report from 03/27/2025 through 03/31/2025 revealed no documented evidence of an order for Tylenol 1000 milligrams or of a STAT x-ray of the left arm. The Medication Administration Record from 03/27/2025 through 03/31/2025 revealed no documented evidence of Tylenol 1000 milligrams being administered to Resident #4. The Facility Investigative Summary dated 03/31/2025 documented Resident #4 reported that they had pain in their left arm. The nurse in charge

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	The findings include:The facility's policy titled 'Pain Assessment' with a review date of 10/2005, directed that every resident will be assessed on admission for pain management and thereafter as medically indicated. Respectively, pain control measures should be used before pain becomes severe. It also directed that the physician was to be notified if measures are unsuccessful or if current complaint is a significant change from the resident's experience. The facility's policy titled 'Change in Resident's Condition', with a review date of 03/2022, directed staff to document any change in a resident's condition and to inform the Medical Doctor and designated representative in a timely fashion. The policy also documented that the resident is placed on the 24-hour report and care is rendered according to need and Medical Doctor's order. The Facility Investigative Summary dated 03/31/2025, documented Resident #4 reported that they had pain in their left arm. The nurse in charge (Registered Nurse #4) assessed the area and administered Acetaminophen, which provided temporary relief. On 03/28/2025, staff observed slight swelling of the left upper arm with continued reports of mild pain. Physician #1 was notified, and an x-ray was ordered, and pain management was adjusted. On 03/31/2025 Resident #4 swelling had increased, and the affected area was noted to be warm to the touch. The resident also began to exhibit altered mental status. Physician #2 evaluated the resident and ordered hospital transfer to rule out Deep Vein Thrombosis and assess mental status change. On 04/01/2025 during a follow up with the hospital, they reported Resident #4 had a left proximal humerus fracture. The report did not indicate if the fracture was acute or chronic. The investigation concluded there was no evidence to suggest abuse, neglect, or staff misconduct in relations to the resident's left proximal humerus fracture. The Director of Nursing documented on 04/01/2025 that Resident #4 complained of left arm pain on 03/27/2025. Registered Nurse #1 assessed the resident and Acetaminophen given with temporary relief. Follow-up with the hospital revealed Resident #4 was admitted with left humeral fracture. The report included a written statement from Registered Nurse #4. In the statement Registered Nurse #4 stated that they assessed the resident for pain on 03/28/2025 and observed the swelling of the left arm. They stated that they notified Physician #1 who ordered stat X-Ray and Acetaminophen 1000 milligrams to be administered to the resident. They did not administer the medication, but informed Licensed Practical Nurse #2 of the order. They did not indicate that they assessed the resident on 03/27/2025. Resident #4 was last admitted to the facility 08/14/2024 with diagnoses including cerebrovascular accident (stroke) with hemiplegia (paralysis to one side of the body) and dementia. The Minimum Data Set (a resident assessment tool) dated 01/02/2025, documented Resident #4 had mentally impaired cognition. Primary language Creole. Resident #4 does not have a pain management regimen; however, a pain assessment interview should be conducted. A Pain Management Care Plan was created on 10/09/2024 and last updated on 01/04/2025. Documentation revealed a quarterly evaluation, and that the resident was stable and verbalized no complaints of pain. Also states that pain medication will be administered as needed per order. Also documented that monitoring will continue for 90 days. There was no documented evidence the Pain Management Care Plan was revised after 01/04/2025.A Nursing Note by Registered Nurse #4, dated 03/31/2025 at 1:47 PM indicated that it was a late entry for 03/28/2025 at 3:20 PM. It documented that Resident #4 had a swollen left arm that was larger than the right and complained of pain. Temperature 98.2, pulse 82, respiration 18, and blood pressure 132/78. Physician #1 was notified via telephone and ordered an x-ray of the left arm and Acetaminophen 1000 milligrams times one (1) received. The note documented a verbal report was given to Licensed Practical Nurse #3 (day shift) of Resident #4 clinical condition and the physician's order for left arm x-ray and Acetaminophen times one dose. There was no documented evidence that Registered Nurse #4 conducted a pain assessment or verified that pain medication was administered to the resident. There was no documented evidence that Registered Nurse #4 informed Licensed Practcial Nurse #3 of the order for an x-ray. The Medication Administration Record from 03/27/2025 through 03/31/2025 revealed no documented evidence of Acetaminophen 1000 milligrams being administered to Resident #4. A Transfer Summary Note by Registered Nurse #1 dated 03/31/2025 at 1:28 PM, documented Resident #4 was being transferred to the hospital to rule out deep vein thrombosis (a blood clot forming in the deep vein) to their left upper extremity and altered mental status. Resident #4 blood pressure was 184/110 and pulse 110.A Nursing Note by the Assistant Director of Nursing dated 03/31/2025 at 7:04 PM, documented that they were called by Registered Nurse Supervisor #1 to evaluate Resident #4. Resident #4 left upper extremity was swollen especially around the left shoulder extending to the resident's neck and left

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated survey (622104), the facility did not ensure licensed nurses have the specific competencies, and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This was evident for one (1) of seven (7) residents (Resident #4) reviewed. Specifically, Resident #4 complained of pain to their left arm on 03/27/2025 and 03/28/2025. Physician #1 was notified on 03/28/2025 and ordered Tylenol 1000 milligrams and a STAT x-ray of the left arm. Registered Nurse #4 stated they did not enter the orders because they did not receive training on the electronic medical record (Sigma). This resulted in a delay in treatment for Resident #4 who was transferred to the hospital on [DATE] at 1:55 PM and was admitted with diagnosis of left arm fracture. Findings include:The policy titled 'Nursing Orientation Program', last reviewed 01/2025 documented it is the policy of this facility to provide all newly hired and agency nursing staff with a structured orientation program prior to assuming independent resident care assignments. This program ensures that all nursing personnel demonstrate the knowledge, skills, and competencies necessary to provide safe, effective, person-centered care in accordance with federal and state regulations, Centers for Medicare & Medicaid Services requirements of participation and facility policies. The policy titled 'Physician's Orders', last reviewed 03/2022 documented physician's orders shall be maintained for each resident in the electronic medical record. The physician/nurse will enter all medication/treatment orders in the physician order section in the Electronic Medical Record. The order will be reviewed by three nurses on consecutive shifts. The policy titled 'Change in Resident's Condition', last reviewed 03/2022 documented it is the policy of Northern Manhattan Nursing Home to document any change in a resident's condition and to inform Medical Doctor and designated representative in a timely fashion. The policy also documented that the resident is placed on the 24-hour report and care is rendered according to need and Medical Doctor order. The facility Policy and Procedure titled Diagnostic Services and Guidelines dated 11/2023 documented upon a physician's order for diagnostic tests, the nursing department will arrange for the specimen to be obtained or tests to be done as per nursing policies and procedures, on a schedule basis or immediately, if the order is for stat tests. Resident #4 was last admitted to the facility 08/14/2024 with diagnoses including Cerebrovascular Accident (Stroke) with hemiplegia and Dementia. The Minimum Data Set (a resident assessment tool) dated 01/02/2025 documented Resident #4 had mentally impaired cognition. Primary language Creole.A Staff Development checklist, for Registered Nurse #4, dated 01/07/2025 revealed no documented evidence of training on the Electronic Medical Record. A Nursing Note by Registered Nurse #4 dated 03/31/2025 (late entry for 03/28/2025) documented Resident #4 had a swollen left arm that was larger than the right and complained of pain. Temperature 98.2, Pulse 82, Respiration 18, and Blood Pressure 132/78. Physician #1 was notified via telephone and ordered an x-ray of the left arm and Tylenol 1000 milligrams times one received. Also documented, a verbal report was given to oncoming Licensed Practical Nurse #3 of the physician's order for x-ray and Tylenol. There was no documented evidence Tylenol was administered, and a STAT x-ray was ordered 03/28/2025.A Physician Order Activity Detail Report from 03/27/2025-03/31/2025, revealed no documented evidence of an order for Tylenol 1000 milligrams and a STAT x-ray of the left arm. The Medication Administration Record from 03/27/2025-03/31/2025, revealed no documented evidence of Tylenol 1000 milligrams was administered to Resident #4. A Nursing Note by the Assistant Director of Nursing dated 03/31/2025 documented that they were called by Registered Nurse Supervisor #1 to evaluate Resident #4. Resident #4's left upper extremity was swollen especially around the left shoulder extending to the resident's neck and left face. There was no bruising noted, and no falls were reported by staff. A Transfer Summary Note by Registered Nurse #1 dated 03/31/2025 documented Resident #4 was being transferred to hospital to rule out Deep Vein Thrombosis to their left upper extremity and Altered Mental Status. Resident #4's blood pressure was 184/110 and pulse 110.A Nursing Note by Licensed Practical Nurse #6 dated 03/31/2025 documented Resident #4 left for the hospital at 1:55 PM. During a telephone interview on 07/10/2025 at 11:52 AM Registered Nurse #4 (former employee/Complainant) stated that on 03/28/2025 at about 3:40 PM Certified Nursing Assistant #3 informed them Resident #4 was complaining of pain, and they both went to the resident's bedside. They stated they assessed the resident and observed that their left arm was slightly swollen (larger than the right arm), and they notified the Physician #1, who gave a telephone order for x-ray of the left arm and Tylenol 1000