STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055964	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRIENDSHIP MANOR NURSING & REHAB CENTER	**902 SOUTH EUCLID AVENUE NATIONAL CITY, CA 91950**

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, a certified nursing assistant (CNA) did not report an injury of unknown origin in a timely manner for one of three residents reviewed (Resident 1). This failure resulted in the delay of an investigation into the cause of the injury. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 6/8/20, a complaint was filed with the California Department of Public Health (CDPH). The complainant stated, on 6/1/20 a bruise was observed on the forehead of Resident 1 while using FaceTime (a video application on a tablet or cellular phone). On 6/8/20 at 1:45 P.M., an interview was conducted with Licensed Nurse 1(LN 1). LN 1 stated she was aware of one recent complaint from a family member regarding a bump on Resident 1's face. LN 1 stated a CNA had noticed the bump prior to the FaceTime call with the family. On 6/8/20 at 2:40 P.M., an observation was conducted of Resident 1. Resident 1 was in bed, asleep and positioned on her back. A light red, irregularly shaped mark, approximately a half inch in diameter, was located near the hairline at the center of Resident 1's forehead. On 6/8/20 at 2:20 P.M., an interview was conducted with CNA 1. CNA 1 stated she had been assigned to work with Resident 1 on 6/1/20. CNA 1 stated she had noticed a red, raised mark on Resident 1's forehead while checking blood pressure on 6/1/20, at approximately 7:30 A.M. CNA 1 stated she then got busy with other residents, and did not inform the nurse (LN 2) until later in the morning. On 6/8/20 at 3:37 P.M., an interview was conducted with LN 3. LN 3 stated she was the charge nurse on 6/1/20 when the bump was reported to her. LN 3 stated LN 2 had informed her of the bump around 11 A.M., after CNA 1 had reported it. LN 3 stated her role was to assess Resident 1's injury. LN 3 stated she went to Resident 1's room, and an activities assistant (AA 1) was using FaceTime with family members. The family had noticed the bump, and LN 3 completed her assessment while the family observed. LN 3 stated she had told the family she had just been informed of the bump. On 6/10/20, a record review was conducted. On 3/20/20, the Minimum Data Set (MDS), section C, indicated Resident 1s Brief Interview for Mental Status (BIMS) was 00, indicating severe cognitive impact. Section G indicated Resident 1 required extensive assist with all activities of daily living. Section G also listed Resident 1 required total assistance to move her upper body. LN 1 wrote in a Progress Note, dated 6/1/20 and timed 12:30 P.M., .Change in skin color or condition .Discoloration .Informed by CNA, she noted purple discoloration on the middle of resident forehead during rounds this morning. But it became more noticeable during transfer .Purple discoloration measures 3x3cm (centimeters) . On 6/10/20 at 12:50 P.M., an interview was conducted with LN 2. LN 2 stated she was assigned to Resident 1 on 6/1/20, and had seen her sleeping at about 7:20 A.M. LN 2 stated she had given Resident 1 her medication at approximately 8:20 A.M., and had not noticed any discoloration. LN 2 stated CNA 1 notified her of the bump on Resident 1s head at approximately 11:40 A.M. Per LN 2, We should always inform the charge nurse immediately. On 6/10/20 at 1:30 P.M., a concurrent interview and record review of the facility's abuse policy was conducted with the Admin and DON. The Admin stated all staff were trained to report any injury or concern immediately. Per a facility policy, titled Reporting of Alleged Violations, revised March 2018, .Reporting/Response .2. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse .
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three residents reviewed was safe from injury (Resident 1). This failure resulted in Resident 1 having a discolored area on her forehead which facility staff could not explain. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 6/8/20, a complaint was filed with the California Department of Public Health (CDPH). The complainant stated, on 6/1/20 a bruise was observed on the forehead of Resident 1 while using FaceTime (a video application on a tablet or cellular phone). On 6/8/20 at 1:45 P.M., an interview was conducted with Licensed Nurse 1(LN 1). LN 1 stated she was aware of one recent complaint from a family member regarding a bump on Resident 1's face. LN 1 stated staff had noticed the bump prior to the FaceTime call, but had not notified the family prior to the facility placing the FaceTime call. LN 1 stated all staff who had worked with Resident 1 had been interviewed regarding the bump but nobody knew what caused it. On 6/8/20 at 2:20 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Certified Nursing Assistant 1 (CNA 1) noticed the bump in the morning, then notified LN 2. LN 2 then informed LN 3. The DON stated all staff who worked with Resident 1 had been interviewed and the investigation did not identify what caused the bump. The DON stated a remote control for the bed, which stayed on the bed, was possibly the cause of the bump. On 6/8/20 at 2:40 P.M., an observation was conducted of Resident 1. Resident 1 was in bed, asleep and positioned on her back. A light red, irregularly shaped mark, approximately a half inch in diameter, was located near the hairline at the center of Resident 1's forehead. A bed control was located on the bed, above Resident 1s left knee. On 6/8/20 at 2:20 P.M., an interview was conducted with CNA 1. CNA 1 stated she had been assigned to work with Resident 1 on 6/1/20. CNA 1 stated she had noticed a red, raised mark on Resident 1's forehead while checking blood pressure on 6/1/20, at approximately 7:30 A.M. CNA 1 stated she had been interviewed regarding the bump, but did not know how it had occurred. CNA 1 stated Resident 1 was unable to use the call light or bed control, and required total care by staff for repositioning, eating, and hygiene. On 6/8/20 at 335 P.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated he had provided education to staff regarding safety for Resident 1. The DSD stated the facility did frequent rounding to check on Resident 1, and had moved the bed controls off of the bed in case it was the cause of the injury. On 6/8/20 at 3:37 P.M., an interview was conducted with LN 3. LN 3 stated she was the charge nurse on 6/1/20 when the bump was reported to her. LN 3 stated LN 2 had informed her of the bump around 11 A.M., after CNA 1 had reported it. LN 3 stated her role was to assess Resident 1's injury. LN 3 stated she went to Resident 1's room, and an activities assistant (AA 1) was using FaceTime with family members. The family had noticed the bump, and LN 3 completed her assessment while the family observed. LN 3 stated she had told the family she had just been informed of the bump and would investigate the cause. On 6/8/20 at 4:10 P.M., an interview was conducted with the DON and the Administrator (Admin). The DON stated all caregivers had been interviewed, and asked about the discoloration on Resident 1's forehead. The DON stated none of the staff had knowledge of how the bump had gotten on Resident 1's forehead. The Admin stated the staff interviews were all grouped into a single document regarding the injury, and he had not asked caregivers to write out statements, as he had not considered the bump to be abuse. On 6/10/20, a record review was conducted. On 3/20/20, the Minimum Data Set (MDS), section C, indicated Resident 1s Brief Interview for Mental Status (BIMS) was 00, indicating severe cognitive impact. Section G indicated Resident 1 required extensive assist with all activities of daily living. Section G also listed Resident 1 required total assistance to move her upper body. LN 1 wrote in a Progress Note, dated 6/1/20 and timed 12:30 P.M., .Change in skin color or condition .Discoloration .Informed by CNA, she noted purple discoloration on the middle of resident forehead during rounds this morning. But it became more noticeable during transfer .Purple discoloration

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) measures 3x3cm (centimeters) . The Interdisciplinary Team (IDT) wrote a report of the incident on 6/2/20. Per the IDT note, the investigation was complete and caregivers had not reported any unusual events happened during their assigned shifts. No changes to Resident 1's care or environment were documented in the IDT note. No explanation was provided for the discoloration on Resident 1's forehead. On 6/10/20 at 12:50 P.M., an interview was conducted with LN 4. Per LN 4, she assessed any residents with skin conditions as part of her job responsibilities. LN 4 stated she had assessed Resident 1 on 6/2/20. Per LN 4, She still had a knot, greenish on the edges and fading. LN 4 stated she could not assess when the discoloration had occurred, as it would have depended on the age of the resident, their overall health, and the location of the discoloration. On 6/10/20 at 12:50 P.M., an interview was conducted with LN 2. LN 2 stated she was assigned to Resident 1 on 6/1/20, and had seen her sleeping at about 7:20 A.M. LN 2 stated she had given Resident 1 her medication at approximately 8:20 A.M., and had not noticed any discoloration. LN 2 stated she had been interviewed about the discoloration, but did not know how it occurred. LN 2 stated she was not aware of any changes to Resident 1s care due to the bump. LN 2 stated Resident 1 was a total care, and needed two people to turn her in bed. On 6/10/20 at 1:30 P.M., a concurrent interview and record review of the facility's abuse policy was conducted with the Admin and DON. The Admin stated the facility had interviewed all staff but did not identify the source of the bump. Per a facility policy, titled Abuse Investigate/Prevent/Report Alleged Violation, revised March 2018, .Injuries of unknown source .2. The Administrator shall delegate .to investigate injuries of unknown source including when both of the following conditions are met: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and b. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) .5. The DNS (Director of Nursing Services) together with .IDT will conduct analysis of interview data, physical assessment, .environmental analysis and all other pertinent data associated with the investigation, to determine a cause or likely probability of cause for the injury of unknown source .