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 _____	03/23/2020

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure professional standards were met when physicians' orders were not followed and physicians where not informed when medications were not available for two of three residents (3 and 17) reviewed for medication administration. This failure had the potential to adversely affect the residents' health. Findings: 1.Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 2/21/20 at 9 A.M, an observation and interview was conducted with Resident 3. Resident 3 was in his room, seated on his bed, he was alert, oriented and well groomed. Resident 3 stated he had been to his cardiologist (heart doctor) appointment on 1/16/20. Resident 3 stated the doctor had ordered an inhaler for him for his occasional shortness of breath (SOB). Resident 3 stated he returned to the facility with the prescription and was told by nursing staff the inhaler would be available from the pharmacy that night (1/16/20). Resident 3 stated he waited several days before he had received his inhaler. Resident 3 stated he had been very upset about not receiving the inhaler and had been afraid his blood pressure would increase because of it. On 2/21/20 a review of Resident 3's medical record was conducted: Per the physician's orders [REDACTED].M., Resident 3 had an appointment with the cardiologist at 11 A.M. that morning. A physician's orders [REDACTED].M. indicated Resident 3 was to receive one puff of an inhaler three times a day for SOB. Per a nursing note dated 1/18/20 at 4:30 P.M., Resident 3 had been at the nurse's desk, upset because the inhaler was still not available. On 2/21/20 at 11:45 A.M., an interview and review of Resident 3's medical record was conducted with LN 10. LN 10 stated Resident 3 should never have waited over two days to receive the inhaler. LN 10 stated the nurses should have contacted Resident 3's doctor when the inhaler was not available. LN 10 stated documentation of the doctor being notified the inhaler was not available for Resident 3 should have been documented by the LN's in Resident 3's medical record. LN 10 stated Resident 3 could have experienced respiratory distress without an inhaler available for use. On 2/21/20 at 2:10 P.M., an interview and record review of Resident 3's medical record was conducted with the ADON. The ADON stated Resident 3's inhaler should have been available for use three to four hours after ordering. The ADON stated Resident 3 could have had respiratory changes without the inhaler. The ADON stated Resident 3's physician should have been notified, and the nurses should have documented, the inhaler was not available. The ADON stated documentation of the doctor being notified of the inhaler not being available for use by Resident 3 could not be located in Resident 3's record. On 2/21/20 at 3 P.M., an interview was conducted with the DON. The DON stated it would be important for Resident 3 to have his medications to maintain any of his medical conditions. The DON stated the nurses should have made Resident 3's physician aware the inhaler was not available for several days and they did not. On 2/28/20 at 4:15 P.M., the DON was interviewed. The DON stated the physician's orders [REDACTED]. 2. Resident 17 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].M., an observation and interview was conducted with Resident 17. Resident 17 was alert, oriented and well groomed. Resident 17 stated she had been admitted to the facility on [DATE] at approximately 8:30 P.M. Resident 17 stated she had been in a lot of pain and had been very anxious. Resident 17 stated the pain medication had not been available to her until the following day. On 2/21/20 a review of Resident 17's medical record was conducted: Per Resident 17's pain evaluation document, dated 2/19/20 at 9:30 P.M., Resident 17 had verbalized back pain at a level 9 on a scale of 0-10 with 10 being the worst pain. The document also indicated pain management intervention had been necessary. Per physician's orders [REDACTED]. 1-2 tablets every 6 hours for pain. A review of Resident 17's MAR indicated [REDACTED].M. On 2/21/20 at 11:15 A.M., an interview and review of Resident 17's medical record was conducted with LN 15. LN 15 stated the first dose of [MEDICATION NAME] had been given to Resident 17 on 2/10/20 at 7:40 A.M. LN 15 stated Resident 17 should never have waited that long to receive pain relief as the resident's physical and mental health could be affected. LN 15 stated if pain medications were not available in the cubex (automated medication dispensing system) for Resident 17, the nurses should have called the doctor. LN 15 stated there was no documentation by the nurses that had been done. On 2/21/20 at 1:30 P.M., an interview was conducted with Resident 17. Resident 17 stated her pain was so bad on 2/19/20 that she had started crying, screaming, and banging her head against the glass sliding door in her room. On 2/21/20 at 1:35 P.M., an interview was conducted with the ADON. The ADON stated the nurses should have called Resident 17's physician and made him aware the medications were not available. The ADON stated unrelieved pain adversely affected residents physically and emotionally. On 2/21/20 at 3 P.M., an interview was conducted with the DON. The DON stated Resident 17 should never have waited almost 12 hours to receive pain medication. The DON stated he could have accessed the cubex system to get the pain medication for Resident 17. The DON stated the nurse should have contacted me and the physician but did not. On 2/28/20 at 3:15 P.M., an interview was conducted with LN 16. LN 16 stated Resident 17 should never have waited almost 12 hours to receive pain medication, the doctor should have been called if the medication had not been available. LN 16 stated the doctor could have called the pharmacy to have the medication delivered as soon as possible. LN 16 stated she was aware the DON would have been able to access the cubex system and she should have called him but did not. On 2/28/20 at 4:15 P.M., an interview was conducted with the DON. The DON stated Resident 17's physician's orders [REDACTED]. The facility did not provide a policy specific to following physician orders [REDACTED].

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