STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. BUILDING _____ B. WING _____	03/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARLORA POST ACUTE REHAB HOSP	3801 E ANAHEIM ST LONG BEACH, CA 90804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify a resident's physician when there was a continuous change of condition (COC) with difficulty in breathing and adhere to its policy and procedure which indicated that the attending physician would be notified immediately in the event a resident had a change of condition and if the condition continued to deteriorate to call 911 (emergency services) for one of three sampled residents (Resident 1). (Crossed referenced to F684). This deficient practice of not reporting Resident 1's continuous COC resulting in a delay in diagnosis, care and treatment and the resident's family member (FM 1) calling 911 (emergency services) for Resident 1 to be transfer red to a general acute care hospital (GACH). Resident 1 was readmitted to the GACH within 24 hours of admission to the skilled nursing facility (SNF) after experiencing a change of condition (COC). In the emergency department (ED) Resident 1 required an emergency intubation ((ET) a tube placed in the trachea for air exchange) and was admitted into the intensive care unit ((ICU) a unit for residents who requires a higher level of care (critical care)) for further care and treatment. Findings: A review of Resident 1's GACH Discharge Summary prior to admission to the SNF, dated 11/15/19 indicated Resident 1 had an acute hypoxic [MEDICAL CONDITION] (fluid build-up in the air sacs of the lungs), septic shock (wide spread infection), obstructive sleep apnea (complete or partial obstruction during sleep) requiring continuous positive airway pressure (([MEDICAL CONDITION]) continuous positive airway pressure a treatment for [REDACTED]. A review of Resident 1's GACH medications and treatments indicated the following were administered at the GACH: 1. [MEDICATION NAME] (a medication that relax muscles in the airway to increase air flow to the lungs) 3 milliliters (ml-a unit of measure) nebulizer ((neb)-a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) every 4 to 6 hours while awake and when necessary for shortness of breath (SOB) or wheezing (a [MEDICATION NAME] sound made when breathing). 2. [MEDICATION NAME] (a drug that loosens and thins mucus) 10% 2 ml neb every 4 hours while awake. 3. [MEDICAL CONDITION] (positive airway pressure breathing device to treat sleep apnea/ delivers pressurized air to regulate the breathing pattern). A review of Resident 1's skilled nursing facility (SNF) Admission Record indicated Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 1's admission vital signs included a blood pressure (BP) of 130/70 (unit of measurement) (normal reference range (NRR) is 139/70-120/70), heart rate 84 beats per minute (bpm) (NRR is 60-100 bpm) and respiratory rate of 21 breaths per minute (bpm) (NRR is 12-20 bpm). Resident 1's pulse oximeter (an electronic device that measures the saturation of oxygen carried in the red blood cells) measured at 95% (NRR is 95-100%) on room air with clear breath sounds in both lungs, no cough and regular respirations. Resident 1 was alert and oriented to person and place with verbal coherent communication and the ability to understand others. Resident 1's neurological status (mental state) was within normal limits. The medication list was obtained from the GACH transfer form and the admission orders [REDACTED]. A review of Resident 1's SNF Order Summary Report dated 11/15/19 indicated the following orders: 1. Oxygen 2-3 liter per minute (LPM) via nasal cannula (a plastic tube for oxygen infusion) continuous. 2. [MEDICATION NAME] (([MEDICATION NAME]) medication used to remove excess fluid from the body) and Losartan potassium (blood pressure medication) each once a day for hypertension (high blood pressure (HTN)). 3. Lubriprostone (used to treat irritable bowel syndrome) 24 micrograms (mcg) one capsule two times a day for [MEDICAL CONDITION] (A [MEDICAL CONDITION] disease of the liver resulting in scarring and liver failure). 4. [MEDICATION NAME] HCL (medication to help control blood sugar levels) 1000 milligrams (mg) one tablet two times a day for diabetes (high blood sugar level). 5. Simivastatin (cholesterol lowering medication) 40 mg tablet at bedtime for HLD (hypersensitivity lung disease). 6. [MEDICATION NAME] (allergy medication) 1 tablet every 24 hours as needed for allergy. A review of Resident 1's physician telephone orders, dated 11/16/19 and noted at 5:53 a.m., indicated the following orders: 1. Discontinue [MEDICATION NAME], losartan, Lubiprostone and [MEDICATION NAME]. 2. Accu-check (blood sugar monitoring) before meals and at hour of sleep and cover with regular insulin ((a short acting, form of the hormone) the body uses insulin to process blood sugar). A review of Resident 1's History and Physical (H/P), dated 11/16/19, within 24 hours of admission indicated the resident had decreased breath sounds and the resident did not have the capacity to understand and make decisions. A review of Resident 1's Medication Administration Record (MAR) of the physician's orders [REDACTED]. [MEDICATION NAME] 10% 2 ml neb every 4 hours while awake to loosen secretions 3. Oxygen (O2) 2-3 LPM via nasal cannula continuous three times a day 4. Monitor oxygen saturation (the percentage of oxygen is in the blood) every shift three times a day 5. [MEDICATION NAME] (a synthetic drug used to relieve rheumatic and allergic conditions and to treat [MEDICAL CONDITION]) 20 mg one time a day for [MEDICAL CONDITION] 6. Accu-checks (blood sugar monitoring) before meals and at bedtime cover with regular insulin for diabetes mellitus ((DM) high blood sugar) 7. [MEDICATION NAME] ((an insulin) a hormone that works by lowering levels of glucose in the blood) Solution 100 units/ml 10 at bedtime for DM 8. [MEDICATION NAME] HCL 500 mg two times a day for DM 9. [MEDICATION NAME] 40 mg one tablet a day for high blood pressure (HTN) 10. [MEDICATION NAME] (a medication used to treat high blood pressure) extended release (XR-the drug takes longer to clear from the body) 25 mg one time a day [MEDICAL CONDITION]. Losartan Potassium) 50 mg one time a day [MEDICAL CONDITION]. [MEDICATION NAME] HCL (a medication designed to raise the blood pressure) 2.5 mg every 8 hours for orthostatic (change in position from lying down to standing) low blood pressure 13. Lubiprostone 24 mcg two times a day for [MEDICAL CONDITION] (scarring of the liver) 14. Apixaban 2.5 mg two times a day for [MEDICAL CONDITION] (blood clot prevention) 15. [MEDICATION NAME] 40 mg at bedtime for HLD (abnormally high concentration of fats in the blood) 16. Aspirin 81 mg one time a day for stroke prevention A review of Resident 1's Medication Administration Record for the month of November 2019 indicated the following medications and treatments were not administered as prescribed by the physician on 11/15/19 and 11/16/19: [MEDICATION NAME], Aspirin, Losartan, [MEDICATION NAME] HCL, [MEDICATION NAME], apixaban, [MEDICATION NAME] and lubiprostone. On 11/15/19, there was no oxygen saturation monitored and documented on the MAR for 11-7 a.m. shift as ordered by the physician. On 11/15/19 and 11/16/19, there was no documentation of Resident 1's blood sugar monitoring as prescribed by the physician. A review of Resident 1's progress nurses notes, dated 11/15/19 and 11/16/19 indicated there was no documentation Resident 1's physician was notified as to why the resident did not receive the prescribed medications and treatments. On 11/16/19, the [MEDICATION NAME] and [MEDICATION NAME] breathing treatments were not administered as prescribed at 12 a.m., 4 a.m., 8 a.m. and 12 noon . There was no documentation for the reason the medications and breathing treatments were not administered. A review of Resident 1's nursing progress notes indicated there was no nursing documentation from 11/15/19 at 9 p.m. until 11/16/19 at 8:23 a.m. A review of a nursing progress note dated 11/16/19 at 8:23 a.m. indicated Resident 1's [MEDICAL CONDITION] machine was delivered without a power adapter (not usable). A review of Resident 1's nursing progress note, dated 11/16/19 at 9:48 a.m., indicated all of Resident 1's admission orders [REDACTED]. Resident 1's medication list was updated, transcribed (put in written form), and faxed to pharmacy. A review of Resident 1's nursing progress note, dated 11/16/19 at 10:33 a.m.

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

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.

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F 0580 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) indicated at approximately 9:50 a.m., Resident 1 was noted with increased respirations (breathing) and congestion (stuffiness, or a runny nose is generally caused by increased blood volume to the vessels that line the passages inside the nose (feeling of fullness in the sinuses)). The note indicated Resident 1's oxygen saturation had decreased to 80% (normal range 92 to 100%) and a breathing treatment was provided, and the resident was suctioned. The nursing progress note indicated the NP ordered to increase Resident 1's oxygen to 5 liters, give [MEDICATION NAME] 40 mg IVP (intravenous (into the vein) push) and give breathing treatments every 4 hours around the clock (ATC) and a STAT (immediate) chest x-ray. A review of a nurse's progress note dated 11/16/19 at 12 noon indicated Resident 1's family member (FM)1 came to the nursing station stating Resident 1 had troubled or labored breathing (abnormal respiration and an increased effort to breathe). The note indicated Resident 1's oxygen saturation level fluctuated between 88-90%. FM 1 requested the resident be transferred to the GACH. The nursing note indicated the paramedics were called and the oxygen was increased to 10 liters per minute. The paramedics arrived and transferred the resident to the GACH. A review of Resident 1's Paramedic Run Sheet, dated 11/16/19 at 12:05 p.m., indicated Resident 1 was conscious (awake and alert) and coherent (rational). The paramedics documented Resident 1 had been complaining of shortness of breath (SOB) since that morning and was found with a low oxygen saturation that did not get better with increase of oxygen to 10 liters per minute. Resident 1's vital signs were recorded as follows; a low blood pressure (BP- the pressure of the blood in the circulatory system,) of 96/54 (normal range 120/80), an elevated pulse of 108 beats per minute (normal range-80 beats per minute (bpm), respirations of 20 breaths per minute (normal range 16 to 20 breaths per minute) and oxygen saturation at 100%. A review of Resident 1's GACH Emergency Department (ED) documentation, dated 11/16/19 at 12:44 p.m. indicated Resident 1 arrived at the ED with [MEDICAL CONDITION](increased heart rate) and tachypneic (fast, shallow breathing) with impending (about to happen) [MEDICAL CONDITION]. Resident 1's chest x-ray revealed an almost complete whiteout on the left lung field which suggested due to a left lung collapse and/or from a mucus plug (large collection of mucus). Resident 1 required an endotracheal intubation ((ET) a tube placed in the trachea for air exchange) and was admitted into the GACH's intensive care unit ((ICU) a unit for residents who requires a higher level of care (critical care)) for further care and treatment. Resident 1's treatment included [MEDICATION NAME] (breathing treatment), postural drainage (position to encourage drainage by gravity) and chest PT (physiotherapy/clapping of the chest wall to loosen mucus from the lungs). A review of Resident 1's GACH note, dated 11/18/19 indicated the resident was extubated (tube in trachea removed). The note indicated Resident 1 refused to return to the prior SNF but agreed for admission to another SNF 2. On 11/22/19, the resident was transferred to the SNF 2. On 11/27/19 at 11:08 a.m., during an interview, Certified Nurse Assistant (CNA) 1 stated, After breakfast Resident 1 was observed to be short of breath (SOB) and looked tired. Resident 1 was not receiving oxygen at that time . CNA 1 was unable to recall the resident's mental status at that time. CNA 1 stated Resident 1 was nonverbal and only respond by nodding her head. On 1/23/2020 at 1:45 p.m., during an interview, Licensed Vocational Nurse (LVN) 1 stated on 11/15/19 the [MEDICAL CONDITION] machine was delivered without the power cord. The resident slept without the [MEDICAL CONDITION] machine as ordered by the physician. LVN 1 stated Resident 1's condition changed due to SOB. LVN 1 stated he did not give the resident any medications or breathing treatments, as ordered by the physician, but the registered nurse (RN) 1 gave the resident the [MEDICATION NAME]. On 1/23/2020 at 3 p.m., during an interview, RN 1 stated LVN 1 notified her of the resident's COC and she notified the NP . RN 1 stated she was in between two emergency situations and could not recall giving Resident 1 the [MEDICATION NAME] IVP (intravenous push) and/or the breathing treatment. On 1/24/2020 at 10:45 a.m., during a telephone interview, the facility's contracting pharmacist ((Pharmacist 1) a medication expert) stated the orders for Resident 1 was received on 11/15/19 after 10 p.m. Pharmacist 1 stated LVN 1 called the pharmacy on 11/16/19 and stated Resident 1's orders that were faxed on 11/15/19, which was incorrect. Then a nursing staff member called back on the same day at 1:15 p.m. and informed the pharmacist not to send any medications because the resident went to the GACH. On 2/6/2020 at 10:40 a.m., during an interview, RN 2 stated Resident 1 was tired when she arrived at the facility. The resident's oxygen saturation was 95% on room air and the resident did not need oxygen. On 2/6/2020 at 11:21 a.m., during an interview, Resident 1's primary care physician (PCP) 1) stated he was not called about Resident 1's change of condition (COC) due to difficulty in breathing. On 2/6/2020 at 12:31 p.m., during a telephone interview, FM 1 stated when he arrived to visit Resident 1 and there was no staff in Resident 1's room. FM 1 stated Resident 1's face was red, and he could hear the noises coming from the resident's lungs. FM 1 stated Resident 1 had on oxygen face mask but was unable to catch her breath. FM 1 stated he immediately ran out to the nurse's station to get the nurse, as he (FM 1) called 911. On 2/7/2020 at 3:45 p.m., during an interview and review of Resident 1's physician's orders [REDACTED]. RN 3 stated the orders were verified with the resident's physician but could not recall the physician's name. RN 3 stated she missed verifying Resident 1's new medication and treatment orders that was included in the package. RN 3 denied placing oxygen on Resident 1. RN 3 stated she verified Resident 1's admission orders [REDACTED]. On 2/11/2020 at 8:30 a.m. and 3:40 p.m., during the interviews, LVN 2 stated she was Resident 1's medication nurse on 11/16/19. LVN 2 stated there was a delay in receiving Resident 1's medication and that was why she did not administer any medications or breathing treatments to Resident 1. A review of the facility's policy and procedure titled, Change of Condition Notification, revised on 1/1/17 indicated the purpose was to ensure the physicians were informed of changes in the resident's condition in a timely manner. The policy indicated the facility would promptly consult with the resident's attending physician when the resident endures a significant change in the resident's physical, cognitive, functional and behavioral status (example given) e.g., deterioration in health, life threatening conditions or clinical complications. The policy also stipulated in emergency situations, e.g., the resident is experiencing unexpected shortness of breath, the Licensed Nurse (LN) would- Immediately call the attending physician, if unable to reach the physician or the physician on-call during emergency situations, he/she would notify the facility's Medical Director. The policy also indicated, If the resident deteriorates, the symptoms are serious, and the most rapid intervention available by a physician would place the resident in great jeopardy, call 911 for transport to hospital.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident received medications and breathing treatment, as prescribed by the physician for one of three sampled residents (Resident 1). Resident 1 did not receive the medications and respiratory treatments as prescribed by the physician, which resulted in a change of condition (COC). This deficient practice of not reporting Resident 1's continuous change of condition which resulted in a delay in diagnosis, care and treatment and the resident's family member (FM 1) calling 911 (emergency services) for Resident 1 to be transferred to a general acute care hospital (GACH). Resident 1 was readmitted to the GACH within 24 hours of admission to the skilled nursing facility (SNF) after experiencing a COC due to not receiving the prescribed medications, oxygen and treatments. In the emergency department (ED) Resident 1 required an emergency intubation ((ET) a tube placed in the trachea for air exchange) and was admitted into the intensive care unit ((ICU) a unit for residents who requires a higher level of care (critical care)) for further care and treatment. Findings: A review of Resident 1's GACH Discharge Summary prior to admission to the SNF, dated 11/15/19 indicated Resident 1 had an acute hypoxic [MEDICAL CONDITION] (fluid build-up in the air sacs of the lungs), septic shock (wide spread infection), obstructive sleep apnea (complete or partial obstruction during sleep) requiring continue positive airway pressure (([MEDICAL CONDITION]) continuous positive airway pressure a treatment for [REDACTED]. A review of Resident 1's GACH medications and treatments indicated the following were administered at the GACH: 1. [MEDICATION NAME] (a medication that relaxes muscles in the airway to increase air flow to the lungs) 3 milliliters (ml-a unit of measure) nebulizer ((neb)-a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) every 4 to 6 hours while awake and when necessary for shortness of breath (SOB) or wheezing (a [MEDICATION NAME] sound made when breathing). 2. [MEDICATION NAME] (a drug that loosens and thins mucus) 10% 2 ml neb every 4 hours while awake. 3. [MEDICAL CONDITION] (positive airway pressure breathing device to treat sleep apnea/ delivers pressurized air to regulate the breathing pattern). A review of Resident 1's skilled nursing facility (SNF) Admission Record indicated Resident 1 was admitted to the facility on [DATE] , with [DIAGNOSES REDACTED]. Resident 1's admission vital signs included a blood pressure (BP) of 130/70 (normal reference range (NRR) is 139/70-120/70), heart rate 84 beats per minute (bpm) (NRR is 60-100 bpm) and respiratory rate of 21 breaths per minute (bpm) (NRR is 12-20 bpm). Resident 1's pulse oximeter (an electronic device that measures the saturation of oxygen carried in the red blood cells) measured at 95% (NRR is 95-100%) on room air with clear breath sounds in both lungs, no cough and regular respirations.

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Resident 1 was alert and oriented to person and place with verbal coherent communication and the ability to understand others. Resident 1's neurological status (mental state) was within normal limits. The medication list was obtained from the GACH transfer form and the admission orders [REDACTED]. A review of Resident 1's SNF Order Summary Report dated 11/15/19 indicated the following orders: 1. Oxygen 2-3 liter per minute (LPM) via nasal cannula (a plastic tube for oxygen infusion) continuous. 2. [MEDICATION NAME] ([MEDICATION NAME]) medication to remove excess fluids from the body) and Losartan potassium each once a day for hypertension (high blood pressure (HTN)). 3. Lubriprostone 24 micrograms (mcg) one capsule two times a day for [MEDICAL CONDITION] (a [MEDICAL CONDITION] disease of the liver resulting in scarring and liver failure). 4. [MEDICATION NAME] HCL 1000 milligrams (mg) one tablet two times a day for diabetes (high blood sugar level). 5. [MEDICATION NAME] 40 mg tablet at bedtime for HLD (hypersensitivity lung disease). 6. [MEDICATION NAME] 1 tablet every 24 hours as needed for allergy. A review of Resident 1's physician telephone orders, dated 11/16/19 and noted at 5:53 a.m., indicated the following orders: 1. Discontinue [MEDICATION NAME], losartan, Lubiprostone and [MEDICATION NAME]. 2. Accu-check (blood sugar monitoring) before meals and at hour of sleep and cover with regular insulin ((a short acting, form of the hormone) the body uses insulin to process blood sugar). A review of Resident 1's History and Physical (H/P), dated 11/16/19 , within 24 hours of admission indicated the resident had decreased breath sounds and the resident did not have the capacity to understand and make decisions. A review of Resident 1's Medication Administration Record (MAR) of the physician's orders [REDACTED]. 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LVN 1 stated he did not give the resident any medications or breathing treatments, as ordered by the physician, but the registered nurse (RN) 1 gave the resident the [MEDICATION NAME]. On 1/23/2020 at 3 p.m., during an interview, RN 1 stated LVN 1 notified her of Resident 1's COC and she notified the NP. RN 1 stated she was in between two emergency situations and could not recall giving Resident 1 the [MEDICATION NAME] IVP (intravenous push) and/or the breathing treatment. On 1/24/2020 at 10:45 a.m., during a telephone interview, the facility's contracting pharmacist ((Pharmacist 1) a medication expert) stated the orders for Resident 1 w ere received on 11/15/19 after 10 p.m. Pharmacist 1 stated LVN 1 called the pharmacy on 11/16/19 and stated Resident 1's orders that were faxed on 11/15/19, which were incorrect . Then a nursing staff member called back on the same day at 1:15 p.m. and informed the pharmacist not to send any medications because the resident went to the GACH. On 2/6/2020 at 10:40 a.m., during an interview, RN 2 stated Resident 1 was tired when she arrived at the facility. The resident's oxygen saturation was 95% on room air and the resident did not need oxygen. On 2/6/2020 at 11:21 a.m., during an interview, Resident 1's primary care physician (PCP) 1) stated he was not called about Resident 1's change of condition (COC) due to difficulty in breathing. On 2/6/2020 at 12:31 p.m., during a telephone interview, FM 1 stated when he arrived to visit Resident 1 and there was no staff in Resident 1's room. FM 1 stated Resident 1's face was red, and he could hear the noises coming from the resident's lungs. FM 1 stated Resident 1 had on oxygen face mask but was unable to catch her breath. FM 1 stated he immediately ran out to the nurse's station to get the nurse, as he (FM 1) called 911. On 2/6/2020 at 2:48 p.m., during an interview, the NP stated she did not see Resident 1 in the facility because she does not go to the facility to see residents. The NP stated she was currently out of town and was unable to continue the interview and abruptly hung up the phone. On 2/7/2020 at 3:45 p.m., during an interview and review of Resident 1's physician's orders [REDACTED]. RN 3 stated the orders were verified with the resident's physician but could not recall the physician's name. RN 3 stated she missed verifying Resident 1's new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. BUILDING _____ B. WING _____	**03/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARLORA POST ACUTE REHAB HOSP	**3801 E ANAHEIM ST LONG BEACH, CA 90804**

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 -** Actual harm **Residents Affected -** Few	(continued... from page 3) medication and treatment orders that was included in the package. RN 3 denied placing oxygen on Resident 1. RN 3 stated she verified Resident 1's admission orders [REDACTED]. On 2/11/2020 at 6:30 a.m., during an interview, RN 4 stated she provided care to Resident 1 on 11/15/19 during the night shift (11 p.m.-7 a.m.). RN 4 stated she received a report regarding Resident 1's respiratory diagnoses. RN 4 stated there were no medications delivered for Resident 1. RN 4 stated she verified the confusing admission orders [REDACTED]. On 2/11/2020 at 8:30 a.m. and 3:40 p.m., during the interviews, LVN 2 stated she was Resident 1's medication nurse on 11/16/19. LVN 2 stated there was a delay in receiving Resident 1's medication and that was why she did not administer any medications or breathing treatments to Resident 1. A review of the facility's policy and procedure titled, Physician order [REDACTED].