

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055964	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Friendship Manor Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to implement measures to prevent pressure injury (damage to the skin and underlying tissue caused by prolonged pressure on a specific area of the body) when there was no monitoring for the use of a protective head gear (helmet) for one of the two residents reviewed for pressure injury. (Resident 2).This failure had the potential to cause the development of pressure injury.Resident 2's record was reviewed. Resident 2 was readmitted to the facility on [DATE], with diagnoses which included right hemiparesis and hemiplegia (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) and epilepsy (a condition where a person's brain activity becomes abnormal, causing seizures), per the facility's admission Record.On 7/21/25 at 9:16 A.M., an observation was conducted with Resident 2 in her room. Resident 2 was seated in the wheelchair with the helmet on. Resident 2 was non- verbal, but she was able to answer questions by nodding her head.A record review of Resident 2's nursing readmission record, dated 6/17/25, there was no documentation of the protective head gear as a medical device used for Resident 2.A record review of Resident 2's Treatment Administration Record (TAR) indicated no monitoring was in place to assess the skin potentially being affected by the use of a protective helmet.On 7/21/25 at 3:25 P.M., an interview was conducted with Licensed Nurse (LN) 1. LN 1 stated Resident 2 used the helmet when she is out of bed or in her wheelchair.On 7/22/25 at 1:07 P.M., an interview was conducted with a certified nursing assistant (CNA) 1. CNA 1 stated Resident 2 used the helmet when she was out of bed and when seated in her wheelchair. CNA 1 stated the Helmet was to protect her head due to her head surgery. CNA 1 stated whoever the CNA was assigned to Resident 2 would place the helmet on when she was up and would remove the helmet when Resident 2 was back in bed.On 7/23/25 at 10:49 A.M., an observation was conducted with Resident 2 in her room. Resident 2 was up in her wheelchair wearing the helmet.On 7/23/25 at 4:15 P.M, an interview and joint record review was conducted with LN 2. LN 2 stated there was no order found for the use of the helmet and there was no documentation found in Resident 2's TAR that skin integrity was assessed and monitored when Resident 2 used the helmet. LN 2 stated it was important to monitor the skin integrity to prevent pressure injury from the helmet.On 7/24/25 at 8:49 A.M., an interview was conducted with CNA 2. CNA 2 stated Resident 2 used the helmet when she was up in the wheelchair. CNA 2 stated the helmet should be tight enough to ensure the head was stable and not moving. CNA 2 stated she would put the helmet on Resident 2 and would remove it when Resident 2 returned to her bed. On 7/24/25 at 1:29 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that there should have been an order obtained for the helmet and staff should be monitoring the skin to ensure that there were no pressure injury for the use of the helmet.A review of the facility's procedures, titled Prevention of Pressure Injuries, revised on 4/20, indicated . provide information regarding identification of pressure injury risk factors and interventions for specific risk factors.Device - related pressure injuries.review and select medical devices.to minimize tissue damage.monitor regularly for comfort and signs of pressure - related injury. Monitoring . Evaluate, report and document potential changes in the skin.		

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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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess and change a peripherally inserted central catheter line (PICC - a long, thin, flexible tube inserted into a vein in the arm and threaded into a large vein near the heart) dressing for one of 18 sampled resident (Resident 40). This failure had the potential for medical complications related to Resident 40's intravenous (IV - delivery of fluids, medications, or nutrients into the body's bloodstream, usually through a needle or catheter inserted into a vein) therapy. According to the facility's admission Record, Resident 40 was admitted on [DATE] with diagnoses that included chronic osteomyelitis (bone infection) of the left ankle and foot. A record review of Resident 40's physician's order report indicated on 6/14/25 there was an order for PICC line dressing change .every 7 days .measure external length of catheter and upper arm circumference. On 7/21/25, at 9:02 A.M., an observation and interview was conducted with Resident 40 in his room. Resident 40 was observed with an IV line on his right upper arm. Resident 40 refused to show the IV dressing and stated he does not remember when the dressing was changed last. On 7/22/25 at 2:42 P.M., a concurrent interview and record review was conducted with licensed nurse (LN) 6. A review of Resident 40's medication administration record (MAR - a detailed chart or document used in healthcare settings to keep track of every medication given to a patient) for July 2025 indicated that on 7/12/25, Resident 40's PICC line external catheter was not measured and the dressing was not changed as ordered by the physician. LN 6 stated that PICC line care was not done and should have been done. On 7/24/25, at 2:20 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that Resident 40's PICC line dressing was not changed but should have been. According to the facility's policy titled Central Venous Catheter Care and Dressing Changes, dated October 2024, the staff must .5. Change the dressing .every 7 days .8. For PICCs, measure arm circumference .		