STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165291	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HAVEN, INC	420 SOUTH KENYON ROAD FORT DODGE, IA 50501

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F 000	INITIAL COMMENTS Correction date: 2/21/24 A re-certification survey and investigation of facility reported incident #116321-I and complaint #116830-C completed January 22 - 25, 2024 resulted in the following deficiencies. Self report #116321-I was substantiated. Complaint #116830-C was not substantiated. See the Code of Federal Regulations (42FR) Part 483, Subpart B-C.	F 000	Please accept this as Friendship Haven's credible allegation of compliance. Friendship Haven denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment no less than 3 months after the last assessment for 2 of 2 residents reviewed (Resident #40 and #105). The facility reported a census of 116 residents. Findings include: 1) The MDS Assessment Lookup for Resident #40 showed she had an admission MDS dated 8/31/23. The record also showed the facility had not completed a quarterly assessment. It had been over 4-1/2 months since the admission assessment.	F 638	Plan of Correction for recertification survey completion date of 1/25/2024, Friendship Haven feels that they responded appropriately and timely to staff education and corrective actions immediately after becoming aware of the incidents in question. Please see the following supportive documentation as proof of immediate substantial compliance as well as additional steps taken to ensure and confirm continued compliance. **F638** 1. *Elements detailing how Friendship Haven corrected the deficiency as it relates to the individual(s):* On 1/25/24 the MDS Coordinator submitted an MDS for resident #40 and resident #105 who were both found to be out of compliance with their quarterly MDS schedule based on their last skilled MDS assessment. 2. *How Friendship Haven will act to protect residents in a similar situation, including measures Friendship Haven will take or systems altered to ensure that the problem does not recur:*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erin Hoversten	Administrator	2/22/24

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 638	Continued From page 1 2) The MDS Assessment Lookup for Resident #105 showed she had an admission MDS dated 9/4/23. On 1/25/24 the record also showed the facility had not completed a quarterly assessment. It had been over 4-1/2 months since the admission assessment. On 01/24/24 at 9:08 a.m. the MDS coordinator said the skilled MDS coordinator did MDS assessments when the resident's went off skilled. She didn't know if that would be considered a Quarterly assessment. On 1/25/24 at 8:14 a.m. the Director of Nursing (DON) stated she would have to look into the MDS issue. At 9:59 a.m. the DON confirmed the assessments for the 2 residents were not done timely.	F 638	All ICF MDS schedules were audited for compliance on 1/25/24 by two Nurse Coordinators and confirmed by the Director of Nursing. MDS changes to be added to daily huddle with interdisciplinary team as discussion topic to prevent problem recurring. 3. *How Friendship Haven plans to monitor performance to make sure that solutions are permanent.* QAPI action plan initiated on 1/25/24 with oversight from interdisciplinary team and board of directors to also be reviewed at medical directors QA meeting.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to accurately complete the Residents' Minimum Data Set (MDS) assessments by not coding for an unhealed pressure ulcer (soft tissue injuries from prolonged pressure to areas of the body) and use of physical restraints for 2 of 2 residents reviewed. (Residents #49 and #76). The facility reported a census of 116 residents. Findings include:	F 641	**F641** 1. *Elements detailing how Friendship Haven corrected the deficiency as it relates to the individual(s):* On 1/25/24 the MDS Coordinator submitted corrective MDS to capture use of restraint for resident #76, and on 2/21/24 submitted scheduled quarterly MDS to capture pressure wound for resident #49. 2. *How Friendship Haven will act to protect residents in a similar situation, including measures Friendship Haven will take or systems altered to ensure that the problem does not recur:* MDS Coordinator has completed coursework for RAC-T certification. MDS Coordinator to collaborate with neighborhood Nurse Coordinator to audit discrepancies between careplan and MDS as needed to ensure accuracy.	

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F 641	Continued From page 2 1. Review of Resident #49's MDS assessment dated 11/30/23, shows an admission date of 1/13/20, with diagnoses of Alzheimer's disease, Dementia, stroke, and incontinent of bowel and bladder, on hospice care with full dependence on staff for transfers and cares. Observations of Resident #49's personal care on 1/25/24 at 8:40 AM revealed a pressure ulcer on the resident's coccyx. Resident #49's MDS assessment dated 11/30/23, lacked documentation of any pressure ulcer. Record review of the Hospice plan of care updates dated 12/7/22 and 9/9/23 noted a Stage 2 pressure ulcer to the coccyx. With treatment to the pressure ulcer ordered by the Hospice Provider. Interview on 1/25/24 at 9:54 AM, the MDS Coordinator and Director of Nursing (DON) confirmed the MDS was not completed accurately and expectations are to complete them accurately. 2. Review of Resident #76's MDS assessment dated 1/4/24, shows an admission date of 3/29/21, with diagnoses of Alzheimer's disease and Dementia, a BIMS score of 3 (indicating severe cognitive impairment), and assist of 1 for transfers. Observation on 1/22/24 at 1:50 PM revealed a merry walker (restraint device with wheels that allows residents to stand and walk at will but limits where they can go) in Resident #76's room.	F 641	3. *How Friendship Haven plans to monitor performance to make sure that solutions are permanent.* Friendship Haven is contracted with Proactive LTC Consulting for quarterly MDS auditing. Director of Nursing to perform quarterly audit of MDSs for 2024 for residents with restraints and or wounds to confirm accuracy in assessments.	

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F 641	Continued From page 3 Record review of the Care Plan dated 1/11/2024 for Resident #76, indicated use of a merry walker to provide least restrictive alternative for safe independent ambulation with assist of 1 to get in and out of merry walker (Resident is not able to get out of merry walker independently) and distant supervision while in use. Resident #76's MDS assessment dated 1/4/24 lacked documentation of physical restraint use. Review of Resident #76's Restraint Record for the month of December 2023, indicated use of the merry walker. Interview on 1/22/24 at 1:50 PM with a staff nurse stated Resident #76 does use the merry walker but not very often. She circles the lounge area when used and is supervised by nurses and CNAs. Interview on 1/25/24 at 11:36 AM, the DON confirmed the MDS was not completed accurately and expectations are to complete them accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656	**F656** 1. *Elements detailing how Friendship Haven corrected the deficiency as it relates to the individual(s):* "Staff A" involved in the witnessed fall was provided a written warning as a result of initial internal investigation on 10/15/23. "Staff A" was provided education on responsibility of knowing and following Point of Care, resident care guide, and resident care plan.	

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F 656	Continued From page 4 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to follow a	F 656	2. *How Friendship Haven will act to protect residents in a similar situation, including measures Friendship Haven will take or systems altered to ensure that the problem does not recur:* On 10/17/23, Simpson Health Center Nurse Coordinators audited all point of care documentation and care plans to ensure proper level of assist for all residents. Nurse Coordinators initiated Point of Care Education Tool template for all direct care staff on all neighborhoods, on proper use of point of care documentation and accountability. Team members signed Point of Care education tool on the re-education received. Cattail Nurse Consulting conducted a mock survey 10/16/23 - 10/18/23 and reviewed the incident as well as our initial investigation and immediate plan of correction was initiated. 3. *How Friendship Haven plans to monitor performance to make sure that solutions are permanent.* Nurse coordinators, neighborhood leads as well as Staff Development Coordinator perform training during the orientation process as well as bi-monthly neighborhood skills fairs. Friendship Haven will continue to have a skills fair with Point of Care documentation for CNAs completed annually. Friendship Haven held an additional skills fair to address compliance with utilizing transfer status as care planned on 11/8/23. Staff Development Coordinator, Nurse Coordinators and Director of Nursing performed monthly audits of Point of Care documentation and Care Plan to ensure compliance for three months to ensure solution was permanent.	

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F 656	Continued From page 5	F 656		

comprehensive Care Plan for 1 of 1 residents reviewed for transfers (Resident #104). The facility reported a census of 116 residents.

Findings include:

The Minimum Data Set dated 11/16/23 documented Resident #104 had diagnoses including hip fracture and non-Alzheimer's dementia. The MDS further documented the resident had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 indicating severe cognitive impairment.

Review of the Care Plan for Resident #104 documented 10/3/23 the resident required assistance of 2.

Review of Progress Notes for Resident #104 dated 10/15/23 revealed the resident was admitted to the hospital with a spontaneous left hip fracture.

During an interview 1/25/24 at 10:05 AM, Staff A, Certified Nursing Assistant (CNA) revealed she took Resident
#104 to the bathroom on 10/15/23. Staff A stated she thought the resident required assistance of 1 at the time and found out later she required assistance of 2. Staff A reported she transferred the resident and heard a "pop" when she went to pivot the resident in the bathroom without additional assistance. Staff A reported the resident's transfer status was updated in the computer immediately and also in the huddle binder. Staff A stated she did not keep up with the huddle binder and did not review the huddle binder 10/15/23 when she arrived at work.

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F 656	Continued From page 6 During an interview 1/25/24 at 1:42 PM, the Director of Nursing revealed there is not a policy in regards to staff following a resident's Care Plan however the expectation to follow Care Plans is taught during the orientation process.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, and staff interview, the facility failed to follow professional standards in regards to physician follow-up with reassessing as needed (PRN) psychotropic medication for 1 of 4 residents reviewed (Resident #26). The facility reported a census of 116 residents. Findings include: The Minimum Data Set (MDS) dated 11/2/23 for Resident #26 documented diagnoses including Alzheimer's disease, anxiety disorder, and depression. The resident's Brief Interview for Mental Status (BIMS) revealed a score of 3 out of 15 indicating severe cognitive impairment. The January 2024 Medication Administration Record (MAR) for Resident #26 revealed the resident was administered PRN topical Lorazepam on 1/8/24, 1/10/24, 1/11/24 and 1/22/24.	F 658	**F658** 1. *Elements detailing how Friendship Haven corrected the deficiency as it relates to the individual(s):* Friendship Haven received a physician order for resident #26 to continue with PRN topical Lorazepam and it was received and noted by nursing on 1/25/24. Residents last GDR review indicated medication needed to be reviewed in 90 days which would have been 12/29/23. The nurse faxed the physician for GDR review request on 12/29/23, the physician signed for continued treatment on 12/29/23 but did not fax the physician order form back to nursing for notation until 1/25/24. 2. *How Friendship Haven will act to protect residents in a similar situation, including measures Friendship Haven will take or systems altered to ensure that the problem does not recur:* The Director of Nursing worked with Pharmacy Director to schedule GDRs to be requested and reviewed by their provider at least two weeks prior to recommended review date. This will allow providers more time to review and return required documentation and provide guidance on medication administration with GDR schedules. 3. *How Friendship Haven plans to monitor performance to make sure that solutions are permanent.* In house pharmacist will do monthly chart reviews for all Simpson Health Center residents and communicate any recommended GDRs to nurse leadership per Friendship Haven's Drug Regimen Review policy.	

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F 658	Continued From page 7	F 658		

The Care Plan for Resident #26 with a start date 11/9/23 revealed the resident was at risk for adverse reactions related psychotropic medication use due to diagnoses of dementia and related aggression. The Care Plan documented a gradual dose reduction (GDR) should be done per pharmacy recommendation quarterly and as needed. The Care Plan further documented the resident took Lorazepam per physician's orders and had Ativan (Lorazepam) gel PRN when refused oral medication but was anxious.

Review of facility form titled Pharmacy Consulting Psychotropic Medications dated 9/21/23 revealed Resident #26 had an order for Ativan gel 3 times a day PRN that needed to be re-evaluated. Review of provider's response dated 9/29/23 documented to continue current Ativan order for treatment of anxiety and will re-evaluate in 90 days.

Review of facility policy and procedures titled Physician's Orders/Telephone Orders effective 5/25/23 documented it is the policy that all resident medications be ordered by a licensed physician/provider. The procedure documented all medications administered to the resident must be ordered in writing by the resident's attending physician or provider.

On 1/25/23 at 8:32 AM the Director of Nursing (DON) revealed via electronic mail that the PRN topical Ativan had not been reassessed and renewed as documented on the pharmacy consultation as the unit manager had a difficult time getting it back form the provider. The DON further revealed it is in the electronic health record notes that it was sent out 12/29/23 for

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F 658	Continued From page 8 re-evaluation. During an interview 1/25/24 at 1:42 PM the DON revealed she would expect a PRN psychotropic medication that was to be evaluated in 90 days by the provider and had not been would be held until the new order was obtained.	F 658		