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 05/18/2023

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 Amended 7/10/23 A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on May 11, 2023 to May 18, 2023. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Residents: 120 Correction date: 5/24/23 The Friendship Haven Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The following deficiencies resulted from the facility's survey regarding the following intakes #109617-I, #110726-I, #110795-C, #111431-I, #111530-C, #112105-I, and #112336-I, conducted May 11, 2023 - May 18, 2023. Facility reported incident #110795-C was not substantiated. Facility reported incident #109617-I, #110726-I, #112105-I and #112336-I and complaint #111530-C were not substantiated in these alleged incidents or complaints, but was considered substantiated due to a separate, unrelated incident. Facility reported incident #111431-I was substantiated.	F 000	Please accept this as Friendship Haven's credible allegation of compliance. Friendship Haven denies it violated any federal or state regulation. 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. Plan of Correction for survey completion date of 5/18/23, Friendship Haven asserts that they responded appropriately and timely to staff education and corrective action immediately after the incident described in this citation with substantial compliance achieved on January 31, 2023. Please see the following supportive documentation for proof of immediate substantial compliance as well as additional steps taken after such date to ensure and confirm compliance. F689 1. Elements detailing how you will correct the deficiency as it relates to the individual. (Fall with Major Injury on 1/30/23). a.On 1/31/23, “Staff A” involved in witnessed fall was provided verbal counseling as a result of initial internal investigation.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erin Hoversten | TITLE: Administrator | (X6) DATE: 06/07/2023

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 689	Continued From page 1 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews, and facility policy review the facility failed to ensure one (1) of four (4) residents received adequate supervision to protect against hazards in the environment (Resident #3). The facility's staff failed to implement safety measures to prevent a fall by not locking the resident's wheelchair brakes and not using a gait belt when transferring a resident. The record review and staff interviews revealed that Resident #3 required assistance with the use of a gait belt for transfers and ambulation. On 1/30/23, one staff member (Staff A, Certified Nurse Aide "CNA") assisted Resident #3 to transfer without a gait belt. As Resident #3 went to sit in the wheelchair, it had one unlocked brake causing the wheelchair to move. As the wheelchair moved and Staff A did not have a gait belt on Resident #3, he fell to the floor. Resident #3 required a transfer to the local emergency room (ER). While at the ER, they determined Resident #3 sustained a right intertrochanteric femoral neck fracture (broken hip). Findings include: Resident #3's Minimum Data Set (MDS) assessment dated 12/6/22 identified a score of 14 of 15 on Brief Interview for Mental Status	F 689	b. On 2/20/23 “Staff A” was provided a written warning as a result of internal investigation and provided written education on Friendship Haven’s gait belt policy and re-signed the document as proof of understanding and education. “Staff A” had signed the document at hire and been trained on these policies and procedures 9/14/22, as well as completed her skills review and competency checklist for onboarding on 9/14/22. 2. How you will act to protect residents in similar situations. a.Friendship Haven Simpson Health Center employee monthly meetings held on Stone Heights 5/17/23, Journeys 5/23/23, Arbor Lane & Terrace View 5/24/23 with focus on fall reduction and rounding with staff re-education and acknowledgment of the “fall management promise” and “gait belt policy”. Audit completed by HR employee files 6/15/23. b. High-risk meeting/huddle with nursing and therapy (IDT team) to discuss falls, medication changes, changes in behaviors and infections from staff interviews and chart review changed from weekly to daily during the week to identify residents at risk for falls, interventions and notifications. c. Therapy department to review falls and screen or evaluate when indicated, they continue to perform quarterly screens or as needed or requested by nursing staff or identified at high-risk meeting. d. Competency checks for gait belt usage and transfer training and education.	

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F 689	Continued From page 2 (BIMS) test, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), cerebrovascular accident (stroke), and respiratory failure. The MDS indicated that Resident #3 required extensive assistance of two persons for dressing, bed mobility, and transfers. Resident #3 did not have a fall since his admission. The Fall Management Promise signed on 9/14/22 by Staff A listed that she promised to do her part to reduce the number of falls the residents experience. She understood that it is up to her to observe the residents and offer interventions that might help keep the resident safe. Staff A realized that resident safety started with her. The Skills Review and Competency Checklists signed by Staff A on 9/14/22 indicated that she completed the transfers/gait belt use. The note listed that she successfullly completed the neighborhood tour and checklist. She felt confident that she could find her way around the building and locate the items listed. Staff A would be responsible and account for the information listed. The Gail Belt Policy signed by Staff A on 9/14/22 instructed to use gait belts for the transfer and ambulation procedures implemented for the residents in the facility. When worn around the waist of a resident, the gait belt assists team members by allowing a secure hold on the resident. It minimizes the risk of resident injury from falls. It minimizes the risk of injury for the team members assisting. The Care Plan Category started 11/20/22 related to activities of daily living (ADL's) indicated that	F 689	e. On 5/23/23 Friendship Haven employee assisted with auditing of gait belt usage and educated all CNAs that the gait belt is part of their daily uniform, skills checks turned into HR for employee files. 3. Include measures you will take or systems you will alter to ensure that the problem does not recur. a. Therapy has daily skilled resident huddle to discuss residents and their progress with therapy as well as fall risk and cognitive decline. b. Therapy, nurse leadership and restorative staff have a weekly huddle to discuss health center residents that are having a decline in physical or mental health status. c. Falls PIP team meeting scheduled bi-weekly to track and trend and discuss interventions for fall reduction/mitigation. d. Continue with bi-monthly skills fairs, agenda for 6/19 and 6/20 to once again cover transfer training and gait belt usage, per our pre-planned annual agenda. e. Fall risk assessments completed on admit by nursing staff as well as again with every fall and at minimum quarterly or as needed with resident changes. 4. How you plan to monitor performance to make sure that solutions are permanent a.Falls PIP bi-weekly meeting and QAPI IDT continues to meet monthly, with QA quarterly with medical director, Falls QAPI/ PIP Action Plan revised on 3/15/23 and continues as an active QAPI currently. b. Continuing with high-risk daily huddle and daily notes with monthly tracking and trending as part of QA process. c. Our QAPI action plan outlines more specific details regarding above mentions action items.	

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Resident #3 needed help to complete his ADLs related to his recent Cerebrovascular Accident (CVA) and weakness. The Care Plan instructed that Resident #3 needed assistance with transfers, ambulation, and dressing. The Interventions directed the following dated 11/30/22:
*Walk to/from the bathroom with front wheeled walker and one assist
*Staff to hold onto gait belt for increased safety.

The Interdisciplinary Notes dated 1/30/23 at 10:19 P.M., at 6:30 p.m. indicated that after arriving to Resident #3's room, they observed him lying on floor in supine position with his head pointed towards entry door and his feet towards the window. The staff witnessed Resident #3's fall. Resident #3 appeared alert and oriented to person, place, and time. The staff reported that as Resident #3 walked from the bathroom to his bed, midway through Resident #3 wanted to remove his jeans to put on his pajama bottoms. When Resident #3 attempted to sit on his wheelchair, it had only one brake locked and resident fell landing on right hip. The staff reported Resident #3 did not hit his head. The assessment revealed that Resident #3 wore shoes for foot wear, his floor did not have clutter, but the staff did not use a gait belt. Range of motion (ROM) to Resident #3's right lower extremity revealed that not with in normal limits. Resident stated "I think I broke my hip." Right hip noted to have some swelling/bulging to anterior aspect. Resident was not able to move right leg without pain.

A Fall Risk Assessment dated 1/31/23 documented a score of 7, indicating a low risk for falls.

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The FSI - Falls Scene Investigation report listed that Resident #3 had a witnessed fall on 1/30/23 at 6:30 p.m. The report identified that Staff A assisted Resident #3 to stand up so he could put his pajamas on. When Resident #3 went to sit down, he only had one side of his wheelchair locked. The wheelchair slid out from underneath him, causing him to land on his right hip. Resident #3 complained of severe pain to right lower extremity and he could not bear weight. Resident #3 had a gait belt but it was not in use at the time of his fall.

An X-Ray report dated 1/30/23 at 7:25 p.m. documented an acute comminuted right intertrochanteric femoral neck fracture related to a fall with pain and deformity.

The Physician Transfer Order Report Instructions dated 2/7/23 at 1:07 p.m. indicated that Resident #3 had a diagnosis of closed fracture of right hip. The instructions directed that he keeps the operative extremity elevated as much as possible and weight bearing as tolerated.

On 5/15/23 at 4:30 p.m., Staff A stated that on 1/30/23 Resident #3 wanted to stand and change from jeans into his pajama bottoms. Staff A confirmed that she did not use a gait belt. She added that when Resident #3 went to sit down in the wheelchair, he did not have one of his wheelchair brakes locked and the wheelchair rolled away causing Resident #3 to fall to the floor. Staff A recalled that Resident #3 complained of pain right away. Staff A explained that she had not checked his Care Plan and was new to the floor at the facility. Staff A reported that she received counseling to always follow the Care

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Plan.

On 5/15/23 at 1:30 p.m., Staff B, Licensed Practical Nurse (LPN), reported that the staff called him to Resident #3's room after he fell. Staff B recalled being surprised right away when he entered the room and he did not have on a gait belt. Staff B replied that he expected all staff when providing transfers use a gait belt.

On 5/15/23 at 5:30 p.m. the facility Administrator confirmed they expected for the staff to follow the Care Plan for resident transfers. In addition, the Administrator expected the staff to use a gait belt for all staff assisted transfers and ambulation.

Staff A's Employee Counseling Report, listed a written warning dated 2/20/23. The report indicated that Staff A assisted Resident #3 with his hour of sleep cares. Staff A did not apply a gait belt when resident stood up from wheelchair to pull pants up. Then as Resident #3 attempted to sit down, the wheelchair did not have one brake locked, resulting in him falling and getting hip fracture. To the form instructed to correct the violation as using a gait belt when assisting a resident from sitting to standing, with transfers, ambulation, and lock wheelchair brakes when resident standing from wheelchair.