

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: 165232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Friendship Home Association		STREET ADDRESS, CITY, STATE, ZIP CODE 714 Division Audubon, IA 50025	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, and staff interviews, the facility failed to ensure the completion of comprehensive discharge summaries-specifically the recapitulation of stay-for 3 of 3 residents sampled (Resident #43, #44, and #45). The facility failed to ensure that mandatory discharge elements, including a summary of diagnoses, course of illness, treatment, therapy, and pertinent diagnostic results, were generated and maintained in the medical record for residents upon discharge. The facility reported a census of 41 residents. Findings include: 1. The MDS for Resident #43 dated 6/19/26 documented a discharge date of 6/19/26, with no return to the facility anticipated. The facility provided a transfer/discharge report for Resident #43; however, the clinical record lacked the required recapitulation of stay. 2. The MDS for Resident #44 dated 3/31/26 documented a discharge date of 3/31/26, with no return to the facility anticipated. The Electronic Health Record (EHR) of Resident #44 contained a signed Discharge Instruction Form and a transfer/discharge report. A recapitulation of stay was not located in the record of Resident #44. 3. The MDS for Resident #45 dated 4/9/26 documented a discharge date of 4/9/26, with no return to the facility anticipated. The facility failed to produce any discharge paperwork other than a signed Discharge Instruction Form; a recapitulation of stay was not located in the record of Resident #45. On 7/29/26, the Administrator stated the EHR software was not configured to generate a recapitulation of stay and that the document was not an available option within the current system configuration. She stated the facility had contacted customer support to resolve the software issue. On 7/30/26, the Director of Nursing confirmed the EHR software vendor was currently correcting the issue and stated the facility also plans to provide staff education and include a resident signature on the completed summary. The Director of Nursing stated the facility does not have a policy regarding discharge documentation or recapitulation of stay.		

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on clinical record review, staff interviews and guidance from the 2025 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to accurately complete Section P (Restraints and Alarms) of the Minimum Data Set (MDS) for 5 of 5 residents sampled (Residents #1, #3, #7, #26, #35). Specifically, the facility erroneously coded the use of bed rails as physical restraints on the MDS assessments. The facility reported a census of 41 residents. Findings include: Section P of the Minimum Data Set (MDS), P0100, documents Physical Restraints as Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.1. The MDS Assessment of Resident #1 dated 5/13/26 documented a bed rail that was used daily as a restraint. The Care Plan of Resident #1 failed to document the use of bed rails or restraints.2. The MDS Assessment of Resident #3 dated 5/20/26 documented a bed rail that was used daily as a restraint. The Care Plan of Resident #3 failed to document the use of bed rails or restraints. 3. The MDS Assessment of Resident #7 dated 5/13/26 documented a bed rail that was used daily as a restraint. The Care Plan of Resident #7 identified turn rails on his bed for independence in bed mobility. The Care Plan failed to document the use of restraints. 4. The MDS Assessment of Resident #26 dated 7/15/26 documented a bed rail that was used daily as a restraint. The Care Plan of Resident #26 identified turn rails to aid in bed mobility. The Care Plan failed to document the use of restraints. 5. The MDS Assessment of Resident #35 dated 6/10/26 documented a bed rail that was used daily as a restraint. The Care Plan of Resident #35 identified turn rails bilaterally to aid in bed mobility and transfers. The Care Plan failed to document the use of restraints. On 7/27/26 at 1:58 PM the MDS Coordinator stated it is a question on the MDS assessment if there are side rails on the bed, so she documents yes. She stated every resident of the facility who utilizes side rails, approximately 15 residents, have been documented this way on their MDS Assessments. She stated the facility does not use any restraints or alarms. She stated she would adjust the assessments accordingly. On 7/29/26 at 12:35 pm, the Director of Nursing stated the facility has no residents who use restraints. She stated the MDS coding would be addressed. She also stated that all residents who have side rails have a yearly assessment for side rails and are only used per resident request. The RAI Manual states the intent of Section P: Restraints and Alarms as the following: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories. The Director of Nursing stated the facility does not have a policy for the accuracy of the MDS Assessments.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, resident and staff interviews, facility reported incident documentation, and facility policy review, the facility failed to conduct a thorough investigation following a resident's fall with injury for 1 of 3 residents reviewed for falls (Resident #3). Specifically, the facility neglected to analyze the circumstances of the incident or interview the involved staff, resulting in an incomplete root cause analysis, hindering the facility's ability to prevent future falls. The facility reported a census of 41 residents. Findings include: The Care Plan of Resident #3 identified a Focus Area of history of falls due to impaired mobility. The Care Plan detailed an intervention stating Fall on 7/10/26 - Staff to assist the resident back to his room after meals, toilet, then chair or bed. The Care Plan failed to identify any toileting schedule or routine of Resident #3 prior to the intervention for a fall on 7/10/26. The facility's incident summary noted that Resident #3 fell in the bathroom on 7/10/26, hitting his head on the wall. He was sent to the hospital and subsequently diagnosed with a brain bleed. The facility document titled Accident Investigation Report detailed the fall was unwitnessed and staff responded immediately upon hearing the fall. It included that the bathroom floor was inspected and found to be dry and free of clutter and that no equipment malfunction or environmental issue was identified as contributing to the fall. The Report Section titled Root Cause Analysis included likely contributing factors of: Resident's underlying fall risk and mobility status. Unwitnessed transfer/ambulation in the bathroom. No environmental hazards were identified that directly contributed to the incident. The opened but incomplete Risk Management Report (Incident Report) failed to document critical investigative information, including staff statements, resident footwear, the time the resident was last visualized, and incontinence status - some items necessary for a complete and accurate root cause analysis. On 7/28/26 at 9:08 am, Resident #3 stated that he thought the fall was a long time ago and he was unable to recall how it happened. On 7/28/26 at 3:20 pm, the Administrator provided the previously submitted Accident Investigation Report and a copy of the Progress Note detailing the fall. When the State Surveyor requested any further documentation of investigative details, the Administrator stated the only witness to hearing the fall was the nurse that wrote the progress note and opened the Risk Management Report. The Incident Note dated 7/10/26 detailed the following: The resident fell in the bathroom and hit his head on the wall. Staff A, Licensed Practical Nurse (LPN) author of the note, detailed that he was several doors down and heard a loud thud. Upon entering the resident's room, the resident was sitting on the floor with his head up against the shower wall of the bathroom. Per the note, the resident stated the only thing hurting was his head and that he did hit his head. Two small skin tears were found on his elbow. Following the nurse's assessment, staff assisted the resident to stand and then to sit in his wheelchair. The resident then was unable to state where he was or his spouse's name, the day of the week, and several times reported that his head hurt. On 7/28/26 at 3:52 pm, Staff B, Certified Nurse Aide (CNA) stated the fall happened just after her shift started. She stated she had not yet rounded on the resident or seen him that day. She stated she did receive a report from the offgoing staff, but could not recall who that staff member was. Review of the resident's clinical record revealed that Staff C, CNA had cared for Resident #3 on the shift prior to the fall. On 7/28/26 at 4:10 pm, Staff C, CNA stated she was unable to recall the specific shift of 7/10/26 but stated she frequently is assigned to the hall which Res #3 resides on. She stated the resident falls a lot and that fall happened after she had left so she was unable to give any specific details. She was able to describe the normal routine of Resident #3. She described that he comes out for meals (eats them in the dining room rather than in his room). She (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated after meals, staff will transfer him to his recliner, and place his wheelchair next to him. She stated the staff usually will take him to the toilet prior to meals but if not, then will take him after meals. She stated usually between 4:30 and 5:00 pm is when residents are taken to the dining room for the evening meal, so toileting is normally in that time frame. She said residents are usually done eating by 6:00-6:15 but added that Resident #3 eats fast and he is often done by 5:30 or so and returns to his room at that time. On 7/29/26 at 12:18 pm, the Director of Nursing (DON) stated this was her first time managing a resident fall with a major injury while acting in her current role as DON. She reported that on the night of the incident, Staff A, LPN called her and she instructed him to make the required notifications to the resident's family and physician. Later that night, the DON received a second phone call from Staff A, during which she was informed of the resident's diagnosis. In the days following the incident, the DON, the Administrator, the Social Services Representative and the MDS Coordinator met to discuss Resident #3's routine, the fall, and interventions that could be put in place to prevent future falls. The DON voiced they reviewed the Progress Note written by Staff A and did also speak to Staff B. When the DON spoke to Staff B, she reported she had not yet seen the resident, as the incident occurred at the beginning of her shift. The DON acknowledged that she did not document her conversation with Staff B, nor did she interview Staff C regarding the fall. On 7/29/26 at 2:27 pm, Staff A, LPN stated he had been in the room next to Resident #3's room and heard a thud and ran in. He stated the resident was in the bathroom, but had not taken his walker with him. The resident was sitting up on the floor. He thought the thud he heard was the resident hitting his head. When asked what footwear the resident was wearing, he stated he thought he had been barefoot as the resident has a habit of removing his shoes and socks. He stated he thought the CNAs had toileted him before he was helped to his recliner, but he did not witness this. He added the resident is care planned to be toileted both before and after meals. He was unable to state with certainty if the resident was incontinent at the time of the fall but did not think he was. The facility policy titled Falls, revision date 5/15/26 detailed the following: Point 7: Document in the progress notes the following information:Date and timePerson reporting the event (What alert staff to event - noise, call light, etc.)Was the event witnessed? Describe what the staff member saw.Location of the event. Be specific.Physical description of the resident, position on floor, position of extremities.Assessment for injury.Vital signsHead injury.Assess for cause:Statements by the residentEnvironmental issuesPersonal care issues: Last toileted, shoes on; shoes need repair; don't fit, wheelchair unlocked, etcAdaptive Equipment - Was equipment on and in place, was the resident using it; using it appropriately.Point 9: Determine potential causes for the fall and add teaching and/or interventions to the plan of care to prevent another fall from occurring.		