

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/31/2024
NAME OF PROVIDER OR SUPPLIER  Friendship Haven, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  420 South Kenyon Road Fort Dodge, IA 50501	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42441</p> <p>Based on record review, staff interview and policy review, the facility failed to report an allegation of abuse timely after the allegation was made for 1 of 1 residents reviewed for alleged abuse (Resident #1). The facility reported a census of 116 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) score of 99 indicating inability to complete the interview. The resident ' s diagnosis included Alzheimer ' s disease and left pelvic fracture.</p> <p>The Care Plan dated 12/12/24 documented Resident #1 needed assistance to complete activities of daily living including toileting related to history of pelvic fracture and weakness. The resident required staff assistance of one with a walker for transfers and ambulation and used the wheelchair for primary locomotion.</p> <p>The Progress Notes for Resident #1 dated 12/14/24 at 8:18 PM documented the Director of Nursing (DON) received a call from the charge nurse at approximately 4:52 PM informing her that the resident had been involved in an allegation of abuse. At 7:16 PM, Staff A, Registered Nurse (RN), documented a head to toe assessment had been completed on the resident and no marks or bruises were noted on his back or skin. After the assessment, the Department of Inspections Appeals and Licensing (DIAL), family, provider and police were notified.</p> <p>The facility investigation dated 12/14/24 of the allegation included staff interviews. The investigation revealed on 12/14/24 at approximately 4:52 PM, Staff B, Licensed Practical Nurse (LPN) called the DON to inform her of a situation that happened 3 weeks ago. The investigation included a re-enactment in which Staff F, CNA backhanded Resident #1 in the upper back.</p> <p>During an interview on 12/30/24 at 1:32 PM, Staff E, CNA revealed she and Staff F, CNA had sat Resident #1 on the toilet on 11/20/24 and when he was completed Staff E was trying to get the resident to let go of the bar next to the toilet when the resident bit her. Staff E reported Staff F then hit the resident across his back with the back of her hand and told the resident we don't bite people. Staff E stated she then notified Staff C, RN of the incident and that the incident happened around 9-9:15 PM.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/30/24 at 2:30 PM, Staff B, Licensed Practical Nurse (LPN) revealed she could not remember the exact date when Staff D, CNA had reached out to her to ask her about the abuse policy and told her about the alleged incident that she had heard happened about 3 weeks ago. Staff B reported she had been told by Staff D that Resident #1 had bitten one of the CNAs and Staff F had then backhanded him in the back. Staff B stated she then reached out to the DON and the DON and Staff A came in shortly after their conversation and statements were obtained.</p> <p>During an interview on 12/30/24 at 3:04 PM, Staff C, RN stated nobody had told her about the allegation of abuse towards Resident #1 on 11/20/24. Stated if she had been notified she would have separated the CNA from the residents and then called the supervisor and it is most likely the alleged abuser would have been sent home.</p> <p>During an interview on 12/31/24 at 9:40 AM, Staff F, CNA stated on the date of the alleged incident she had been in Resident #1 ' s bathroom with another CNA (stated she could not remember the name of the other CNA) when as the other CNA was pulling the resident ' s shirt down the resident hit the other CNA. Staff F reported she told the resident we can ' t hit other people, that is not nice. Staff F denied hitting the resident across his back or in any other way.</p> <p>An Employee Counseling Report dated 12/14/24 documented Staff E did not follow up to assure the facility abuse policy was followed through on after witnessing a team member hit a resident. Staff E signed the written warning on 12/14/24.</p> <p>An Employee Counseling Report dated 12/14/24 documented on 11/20/24 Staff C allegedly received report from a CNA regarding physical abuse of a resident and did not notify parties per facility policy and procedures. Staff C signed the written warning on 12/17/24.</p> <p>Review of facility policy titled Dependent Adult Abuse, Manual for Handling Abuse Related Issues, effective 3/15/24 documented residents must not be subjected to abuse by anyone including facility staff. Any staff member observing or aware of an abuse situation occurring will make sure the resident is safe and will report it immediately to their Charge Nurse/Supervisor. The Charge Nurse/Supervisor will notify the Administrator or his/her designee, Director of Nursing and/or responsible department head immediately upon receiving notice of a suspected Dependent Adult Abuse or Resident Abuse, and prior to investigating. The Administrator or his/her designee will immediately notify appropriate state entities (DIAL, DHS and/or law enforcement).</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441</b></p> <p>Based on record review, staff interview and policy review, the facility failed to separate an alleged abuser from a resident for 1 of 1 residents reviewed for alleged abuse (Resident #1). The facility reported a census of 116 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) score of 99 indicating inability to complete the interview. The resident ' s diagnosis included Alzheimer ' s disease and left pelvic fracture.</p> <p>The Care Plan dated 12/12/24 documented Resident #1 needed assistance to complete activities of daily living including toileting related to history of pelvic fracture and weakness. The resident required staff assistance of one with a walker for transfers and ambulation and used the wheelchair for primary locomotion.</p> <p>The Progress Notes for Resident #1 dated 12/14/24 at 8:18 PM documented the Director of Nursing (DON) received a call from the charge nurse at approximately 4:52 PM informing her that the resident had been involved in an allegation of abuse.</p> <p>During an interview on 12/30/24 at 1:32 PM, Staff E, CNA revealed she and Staff F, CNA had sat Resident #1 on the toilet on 11/20/24 and when he was completed Staff E was trying to get the resident to let go of the bar next to the toilet when the resident bit her. Staff E reported Staff F then hit the resident across his back with the back of her hand and told the resident we don ' t bite people. Staff E stated she then notified Staff C, RN of the incident and that the incident happened around 9-9:15 PM. Staff E stated she had knowledge of the need to notify the nurse of an allegation of abuse but was not aware of the need to immediately separate the alleged abuser from the resident.</p> <p>An Employee Counseling Report dated 12/14/24 documented Staff E did not follow up to assure the facility abuse policy was followed through on after witnessing a team member hit a resident. Staff E signed the written warning on 12/14/24.</p> <p>Review of facility policy titled Dependent Adult Abuse, Manual for Handling Abuse Related Issues, effective 3/15/24 documented residents must not be subjected to abuse by anyone including facility staff. Any staff member observing or aware of an abuse situation occurring will make sure the resident is safe and will report it immediately to their Charge Nurse/Supervisor. The Charge Nurse/Supervisor will notify the Administrator or his/her designee, Director of Nursing and/or responsible department head immediately upon receiving notice of a suspected Dependent Adult Abuse or Resident Abuse, and prior to investigating. The Administrator or his/her designee will immediately notify appropriate state entities (DIAL, DHS and/or law enforcement).</p>		