

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 09/10/2025
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation, facility policy/procedures, and staff interviews the facility failed to provide a supportive and safe environment for 1 of 3 residents reviewed (Resident #1). On 8/3/25, the facility staff learned of a Certified Nurse Aide (CNA) being accused of taking a photograph of Resident #1. After learning of this allegation, the facility staff allowed the CNA to work with Resident #1 and all other residents for an entire 8 hour shift. The facility identified a census of 122 residents. Findings include: The Minimum Data Set (MDS) dated [DATE], documented Resident #1 with a Brief Interview for Mental Status (BIMS) score of 4 for which indicated severely impaired decision making abilities, displayed physical (hitting, kicking, pushing, scratching, grabbing abusing other sexually) and verbal (threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed towards others (scratching self, public sexual acts, screaming, disruptive sounds) for which occurred daily. The MDS also documented the resident required substantial to maximal assistance with showering/bathing, upper body dressing and dependent with lower body dressing and toileting hygiene, and diagnosis for which included anemia (condition in which the blood does not have enough healthy red blood cells and hemoglobin to carry oxygen throughout the body), coronary artery disease (reduction of blood flow to the heart muscle due to build up of plaque), hypertension (condition in which the force of the blood against the artery walls is too high), Traumatic Brain Injury (injury to the brain caused by an external force), depression and Bi-polar disease. The Care Plan dated 7/1/25, documented Resident #1 had impaired functional status: bed mobility, transfers, toileting, locomotion, eating, grooming, personal hygiene and bathing. Interventions include: 2-person assist with bed mobility, 2-person assist with transfers and EZ lift (a device designed to allow clients to change from sitting to standing posture or vice versa, by wrapping this patient lift sling around clients waist). 1-person assist to help dress upper body and wash face and brush teeth and total assistance with bathing. The Interdisciplinary Notes dated 8/4/25 at 1:02 p.m., documented, Human Resource employee made Administrator aware of social media picture of an employee and this resident at approximately 8:00 a.m., on 8/4/25. Self report completed and information submitted to DIAL (Department of Inspections and Appeals and Licensing) immediately. Family and Primary Care Provider notified. Resident unaware and unable to recall event. Internal investigation initiated. No injuries or adverse events to resident. The Incident Summary dated 8/4/25 at 8:44 a.m., documented a text message sent to Human Resource cellphone by Staff A, homemaker of Journey's neighborhood, regarding a concerning photo she had screenshot on social media (Snapchat) which included a long term care resident, and Staff C, Certified Nursing Assistant (CNA). In photo, caregiver Staff C and Resident #1 are in a split frame side by side, resident is in side lying position with a tie-dyed t shirt on and a purple and green tie blanket, likely lying in her bed with exposed peri area. Review of the Employee Timesheet with a run dated 9/9/25 at 1:15 p.m., revealed Staff C, CNA worked on 8/3/25 from 1:52 p.m., to 10:07 p.m. Observation on 9/8/25 at 2:00 p.m., Resident #1 was lying in bed on her back with a yellow and black blanket over her and wearing a pink sweatshirt. Interview on 9/8/25 at 2:00 p.m., Resident #1 was not able to recall and remember a photograph being taken and would giggle during the interview. Interview on 9/9/25 at 11:30 a.m., Staff B, Registered Nurse (RN) at the facility and also CNA instructor, stated she had CNA students at the facility 8/1/25-8/3/25 and on 8/3/25 at about 2:00 pm it had been brought to her attention a picture had been sent to one of the students in the CNA class of a resident and another CNA at the facility. Staff B stated she recognized both people in the photo. Staff B stated took my students into a room and explained to them that social media and taking pictures was not allowed while they were in the facility and that the perception of others in the facility could cause harm/danger, she explained that it is not appropriate that pictures be taken of any of the residents and sent. Staff B stated did not call any facility staff. Staff B said she was in teacher mode and not in nurse mode, and was more worried about what we were going to do as a college then a facility. Staff B stated I know that I should of called someone from the facility and sent Staff C home, but I messed up on that part. Staff B stated I did not realize until facility called me on 8/4/25 and explained that since I was still a prn employee of the facility that I needed to have called someone on the administrative side and sent Staff C home and separated from other residents at the facility. Interview on 9/9/25 at 4:45 p.m., the facility Administrator acknowledged that Staff C, CNA worked on 8/3/25 from 1:52 p.m. to 10:07 p.m. The Dependent Adult Abuse Policy dated 3/25, documented the policy is that all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy/procedure, employee time card, and staff interviews, the facility failed to protect vulnerable residents from an alleged abuser. On 8/3/25 at 1:30 p.m., facility staff were aware of a photograph that was taken of 1 of 3 residents reviewed (Resident #1). Facility staff allowed the alleged abuser to work their entire shift on 8/3/25 and allowed the alleged abuser to work with Resident #1 and all other vulnerable residents and failed to notify the facility administration of the allegation. The facility identified a census of 122 residents. Finding include: The Minimum Data Set (MDS) dated [DATE], documented Resident #1 with a Brief Interview for Mental Status (BIMS) score of 9 for which indicated moderately impaired decision making abilities, displayed physical (hitting, kicking, pushing, scratching, grabbing others) and verbal (threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed towards others (scratching self, screaming, disruptive sounds) for which occurred daily. The MDS documented the resident required substantial to maximum assistance with showering/bathing, upper body dressing and dependent with lower body dressing, toileting and personal hygiene. The MDS documented diagnosis which included anemia (condition in which the blood does not have enough healthy red blood cells and hemoglobin to carry oxygen throughout the body), hypertension (condition in which the force of the blood against the artery wall is too high) and Traumatic Brain Injury (injury to the brain caused by an external force), depression and bi-polar disease. The Care Plan dated 7/1/25, had focus area of Resident #1 had impaired functional status related to bed mobility, transfers, toileting, locomotion, eating, grooming, personal hygiene and bathing. Interventions include: 2 person assist with bed mobility, 2-person assist with transfers and EZ lift (a device designed to allow clients to change from sitting to standing posture or vice versa, by wrapping this patient lift sling around clients waist), 1-person assist to help with upper body dressing and wash face and brush teeth and total assistance with bathing. The Interdisciplinary Notes dated 8/4/25 at 1:02 p.m., documented, Human Resource employee made Administrator aware of social media picture of employee and this resident at approximately 8:00 a.m., on 8/4/25. Self report completed and information submitted to DIAL (Department of Inspections and Appeals and Licensing) immediately. Family and Primary Care Provider notified. Resident unaware and unable to recall the event. Internal investigation initiated. No injuries or adverse events to resident. The Incident Summary Report dated 8/4/25 at 8:44 a.m., documented, a text message sent to Human Resource cell phone by Staff A, (homemaker) of Journeys neighborhood, regarding a concerning photograph Staff A screen shot on social media (Snapchat) which included a long term care resident, and Staff C, Certified Nursing Assistant (CNA) who is a caregiver. In the photograph, caregiver Staff C, and Resident #1 are in a split frame side by side, resident is in side lying position with a tie dyed t-shirt on and a purple and green tie dye blanket, likely lying in bed with exposed peri area. Review of the Employee Timesheet with a run dated 9/9/25 at 1:15 p.m., revealed Staff C, CNA, was allowed to work on 8/3/25 from 1:52 p.m. - 10:07 p.m. Observation on 9/8/25 at 2:00 p.m., Resident #1 was lying in bed on her back with a yellow and black blanket over her and wearing a pink sweatshirt. Interview on 9/8/25 at 2:00 p.m., Resident #1 was not able to recall or remember a photograph being taken and would giggle during the interview. 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