| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165291 | A. Building<br>B. Wing | 01/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Friendship Haven, Inc | 420 South Kenyon Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 3 residents reviewed (Resident #3) for falls. The facility reported a census of 114 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS identified Resident #3 required partial to moderate assistance for all transfers. The MDS included diagnoses of cerebrovascular accident (stroke), multiple sclerosis (MS), disorientation and repeated falls. The Care Plan with a start date of 10/9/25 revealed Resident #3 had impaired functional status and required assistance of one staff member for all transfers. The Fall Risk Assessment Form revealed a score of 16 indicating Resident #3 was at high risk for falls. The Incident Report (IR) titled Fall Scene Investigation Report dated 1/17/25 at 5:44 PM documented Resident #3 had a fall in her room with no apparent injuries. According to the IR, Staff A, Certified Nursing Assistant (CNA) reported Resident #3 got weak during a transfer and was lowered to the floor. Resident #3 had a fever, cough and tested positive for COVID during fall assessment. The IR documented a gait assistive device was not used at the time of the fall.On 1/21/26 at 1:10 PM, Staff A, CNA reported Resident #3's call light was on, she went to the room and observed Resident #3 was slouched down in her recliner. Staff A said she offered Resident #3 help to sit up. She said usually Resident #3 could sit up by herself. Staff A said you could tell something was off with Resident #3. Staff A said she noticed Resident #3's pants were very wet and she offered to take her to the bathroom. She said she tried to stand Resident #3 up and she felt uneasy and needed to sit back down. She said when Resident #3 was ready, she stood her up again then started to turn her to get into the motorized scooter. Staff A said she was lightly touching/guiding Resident #3's hips, then her legs gave out and she lowered her to the floor. Staff A reported she did not have a gait belt on Resident #3 during the transfer. She said Resident #3 did not hit the floor hard when she was lowered. When asked how she was lowered to the floor, Staff A said she had her arms under Resident #3's arms. She said she made sure that her legs did not get twisted and she did not hit her head on the foot board of her bed. When asked if Resident #3 was supposed to have a gait belt on during transfers, she said yes. She said at the time of the fall she did not know that. She said she had seen other staff members transfer Resident #3 without using a gait belt. Staff A said when she called the nurse to the room due to the fall, the nurse told her to make sure she always had a gait belt on Resident #3. Staff A said she received a phone call from Staff B, CNA/Neighborhood Lead on 1/21/26 asking her about Resident #3's fall. She said Staff B educated her that all residents who require assistance of one with transfers need to have a gait belt on during a transfer. On 1/21/26 at 1:29 PM, the Administrator reported the facility did not have a gait belt policy. She reported the facility had a gait belt acknowledgement form that was signed during orientation.On 1/21/26 at 1:40 PM, Staff B,<br><br>(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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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | CNA/Neighborhood Lead reported it was an expectation for any resident who required assistance of one or two staff members to have a gait belt on during a transfer. Staff B reported she was going to complete a verbal write up for Staff A, CNA for not using the gait belt. The facility form titled Gait Belt Acknowledgement Form signed by Staff A, CNA on 9/13/25 documented the gait belt when worn around the waist may assist team members by allowing a secure hold onto the resident. The gait belt reduces the potential risk of resident and/or employee injury from falls. Nursing personnel (certified and/or licensed) on duty will have access to a gait belt to assist in the performance of transfers and/or ambulation. A facility form titled Employee Counseling report documented Staff A, CNA received a verbal written warning on 1/21/26 for not utilizing a gait belt with a resident during a transfer on 1/17/26. On 1/21/26 at 1:54 PM, the Administrator reported she would expect residents who require staff assistance to use a gait belt during transfers unless it was contraindicated by the care plan or a behavior. |