

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 08/08/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907</p> <p>Based on observations, interviews, and record review, the facility failed to use safety principles while transporting 2 residents in their wheelchairs (Residents #56 and #71). An observation revealed both pushed from the dining area to their rooms without the staff applying foot pedals on to their wheelchairs. Each resident had to hold their feet off the floor during transport. The facility reported a census of 116.</p> <p>Findings include:</p> <p>1. Resident #56's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS documented Resident #56 used a wheelchair and walker in the prior 7 days. Resident #56 required total assistance from staff to wheel 50 feet or more in her wheelchair (w/c). The MDS included diagnoses of Alzheimer's disease, restless leg syndrome, weakness and the presence of a right artificial hip.</p> <p>On 8/5/24 at 12:21 PM, witnessed Staff A, Certified Nurse Aide (CNA), push Resident #56 in her w/c from the dining room back to her room without foot pedals on the w/c. Resident #56 lifted her feet approximately one inch off the floor during the transport. Staff A stated described Resident #56 as usually independent. Sometimes if she got tired, Staff A pushed her. Staff A stated it probably would be safer to put the w/c pedals on the wheelchair prior to pushing a resident. Staff A added Resident #56 seemed tired that day.</p> <p>2. Resident #71's MDS assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. The MDS documented Resident #71 used a wheelchair and walker in the prior 7 days. Resident #71 required total assistance from staff to wheel 50 feet or more in her wheelchair. The MDS included diagnoses of non traumatic brain dysfunction and schizophrenia.</p> <p>On 8/5/24 at 12:19 PM witnessed Staff B, Registered Nurse (RN), push Resident #71 from the dining room to his room without any foot pedals on the w/c. When asked if she felt safe pushing Resident #71, Staff B replied he refused having w/c pedals on. Staff B reported she felt safe to push him in his w/c without the foot pedals on as he usually did a good job holding his feet up. Resident #71's had his feet lifted approximately 1 foot off of the ground.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/5/24 12:30 PM, Staff C, RN, reported it wouldn't be okay to push a resident without foot pedals. She described Staff A as a new employee and she would reeducate them. Staff C explained Staff B shouldn't push Resident #71 in a w/c without the foot pedals. When told Staff B said she felt safe to push Resident #71 without foot pedals, Staff D, Unit Coordinator responded yeah, until it isn't alright. Staff C and Staff D both concurred the staff shouldn't push residents in their w/c without the foot pedals on. They said both of the residents could propel themselves in their w/c's by using their feet.</p> <p>The observation the staff pushed each approximately a distance of 50 to 60 feet.</p> <p>On 8/6/24 at 11:00 AM, the Director of Nursing (DON) acknowledged that it wasn't safe to push residents in their wheelchairs without foot pedals in place. This DON stated she reeducated both staff. She reflected her disappointment of having 1 being a RN.</p> <p>The facility didn't have a policy on wheelchair pedal placement.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>40907</p> <p>Based on observations, interviews, and record review, the facility failed to check proper gastrostomy tube (a tube inserted through a hole in the abdomen into the stomach to administer nutrition and medications) placement prior to administering medications to 1 of 1 resident observed (Resident #49). The facility reported a census of 116 residents.</p> <p>Findings include:</p> <p>Resident #49's August 2024 Treatment Administration Record (TAR) directed the staff to check tube placement prior to morning and evening medication administration. The ordered instructed to use litmus paper to check PH (acidic level) by aspirating 5 milliliters (ml)(cc) of stomach content and then check with the litmus paper. After verification, replace the aspirated contents back in the stomach.</p> <p>On 8/6/24 at 10:02 AM, observed Staff E, Registered Nurse (RN), administer crushed medications diluted in water through Resident #49's gastrostomy tube (g tube). Staff E flushed the g tube before, during, and after administering the medications. Staff E failed to check the g tube placement with the litmus paper as ordered.</p> <p>On 8/6/24 at 11:37 AM, when inquired about checking the g-tube placement, Staff E replied she forgot to check it. She said she flushed it prior to administering the medications but didn't check residual (left over amount) prior to administration of the medications.</p> <p>On 8/6/24 at 1:34 PM, the Director of Nursing (DON) confirmed Resident #49 had orders to both check residual and Litmus test prior to administering medications. The DON acknowledged Staff E forgot to check placement prior to administering Resident #49's medication through the g tube.</p> <p>A Naso Gastric Tubes / Gastrostomy Feeding Tube policy dated June 2023, directed the nurse to check placement per standards of practice or according to Physician orders. The nurse must check the residual per standard of practice or according to the physician orders. The nurse should report the residual amounts according to the perimeters established by the Physician.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441</p> <p>Based on clinical record review, staff interview and policy review, the facility failed to complete post dialysis assessments for 1 of 1 resident reviewed for receiving dialysis (Resident #113). The facility reported a census of 116 residents.</p> <p>Findings include:</p> <p>Resident #113's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS included diagnoses of stage 4 chronic kidney disease and toxic nephropathy (kidney disease). Resident #113 received dialysis in the 14-day lookback period.</p> <p>Resident #113's Physician Orders included the following orders dated 5/7/24:</p> <ul style="list-style-type: none"> a. Vital signs before dialysis 3 times a week b. Vital signs after dialysis 3 times a week c. Assessment in Interdisciplinary Notes 3 times a week <p>The undated Care Plan Problem indicated since Resident #113 returned from the hospital her kidneys still didn't function as they did previously and she had to do dialysis three times a week. The Care Plan Intervention dated 7/1/24 indicated Resident #113 received dialysis starting 5/8/24 three times a week and the nurse needs to assess her before and after dialysis treatment as needed.</p> <p>The Dialysis policy reviewed July 2024 directed an ongoing assessment and monitoring of the resident's condition for complications before and after dialysis treatment. The policy listed the nursing team as responsible for completing the pre and post dialysis assessments. The assessments include documentation regarding vascular access, checking for a thrill (indicating dialysis access is working), a bruit (indicating dialysis access is working), potential bleeding, or other complications.</p> <p>Resident #113's Progress Notes dated 6/1/24 - 8/7/24 reflected post dialysis assessments didn't get completed on 6/3/24, 6/24/24, 7/1/24, 7/10/24, 7/12/24, 7/15/24, and 8/5/24.</p> <p>During an interview on 8/7/24 at 3:09 PM, the Director of Nursing (DON) acknowledged Resident #113 didn't have post dialysis assessments consistently completed. The DON expected the staff complete the post dialysis assessment per policy.</p>		