STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415044	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendly Home Inc The	303 Rhodes Avenue Woonsocket, RI 02895

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50004 Based on record review, staff and resident representative interview, it has been determined that the facility failed to notify the resident representative(s) when there is need to alter treatment significantly for 1 of 2 residents reviewed, Resident ID #1. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health, on 12/23/2024 alleges that the resident was started on several medications, had a foley catheter (a device that drains urine from your urinary bladder into a collection bag outside of your body) inserted and the facility failed to notify the resident's representative regarding these changes in the residents medical status. Additionally, the complainant had multiple concerns relative to the care that the resident received while at the facility and removed the resident from their care. A. Record review revealed Resident ID #1 was admitted to the facility in September of 2024 with diagnoses including, but are not limited to, dementia and cognitive communication deficit. Review of an admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating s/he has moderately impaired cognition. The resident was discharged in November of 2024. Record review of the resident's medical record revealed that the resident had a medical power of attorney (a legal document that appoints someone as their representative and gives that person the power to act on their behalf). Record review of a facility policy titled, Resident Change in Condition dated 10/17/2023, states in part, .The facility will ensure that resident changes in condition are identified timely, reported to the Physician (and Representative when applicable), and documented in the medical record timely .changes in condition include but may not be limited to .change in vital signs . Record review revealed a nursing progress note dated 9/14/2024 at 9:17 AM which revealed that the resident had an elevated blood pressure on admission. It further revealed a new physician's order to give hydralazine (a medication to treat high blood pressure) 25 milligrams (mg) every shift for blood pressures over 145. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional record review failed to reveal evidence that the resident's representative was notified of these changes in the resident's medical status. B. Record review revealed a nursing progress note dated 9/20/2024 at 4:44 PM, which revealed a new physician's order to give losartan (a medication to treat high blood pressure) 25 mg daily. Additional record review failed to reveal evidence that the resident's representative was notified of this change. C. Record review revealed a nursing progress note dated 9/23/2024 at 8:55 PM which revealed a new diagnosis of prostatitis (a disorder of the prostate gland usually associated with inflammation). Additionally, it revealed new physician orders to start Ciprofloxacin (antibiotic) for 10 days and start vitamin b 12 injections twice a week for 4 weeks. Additional record review failed to reveal evidence that the resident's representative was notified of these changes. D. Record review revealed a nursing progress note dated 10/7/2024 at 7:00 PM which revealed the resident was seen by the facility's Nurse Practitioner (APRN) with new orders to insert a foley catheter, schedule a urology consult and start finasteride (a medication given for an enlarged prostate) 5 mg daily. Additional record review failed to reveal evidence that the resident's representative was notified of these changes. During a surveyor interview on 12/30/2024 at 8:53 AM, with the resident's representative, s/he revealed that the facility failed to call or update on the above physician's orders. S/he further revealed s/he would have not agreed with the foley being inserted and made several requests for that to be removed. The representative indicated that s/he was in the facility frequently and felt that these changes could have been easily communicated to him/her while s/he was there. During a surveyor interview on 12/30/2024 at 11:26 AM, with Licensed Practical Nurse, Staff A, she revealed that it is the facility's policy to notify the resident's representative if there is a change in the resident's medical status or if there are new orders when the resident is cognitively impaired. During a surveyor interview on 12/30/2024 at 12:23 PM with the APRN, she revealed that the facility was responsible for updating the resident's representative with all new orders or changes in the residents condition. She further revealed that on occasion while assessing the resident there would be family or friends at the bedside, but she was unaware who his/her medical power of attorney was during that time. During a surveyor interview on 12/30/2024 at 12:49 PM, with the Assistant Director of Nursing, she was unable to provide evidence the residents representative was notified of the above changes in his/her medical status. Cross reference F 684

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 50004 Based on record review, and staff interview, it has been determined that the facility failed to provide treatment and care in accordance with professional standards of practice and failed to follow physician orders relative to administering an as needed blood pressure medication with parameters for 1 of 1 resident reviewed, Resident ID #1 and 1 of 1 resident reviewed for the use of senna plus (two laxatives combined used to treat occasional constipation), Resident ID #1. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health, on 12/23/2024 alleges that the resident was receiving senna plus while having diarrhea, dehydration and an active diagnosis of clostridioides difficile (C. diff-a bacterium that causes an infection of the colon causing diarrhea and dehydration). Additionally, the resident representative had multiple concerns relative to the care that the resident received while at the facility and removed him/her from their care. During a surveyor interview on 12/30/2024 at 8:53 AM, with the complainant, s/he revealed that the resident was receiving unnecessary medications for his/her blood pressure and stated, [S/he] was being harmed by the facility administering a laxative while [s/he] was dehydrated and having diarrhea. A. According to Mosby's 4th Edition, Fundamentals of Nursing page 314, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients. Record review revealed that Resident ID #1 was admitted to the facility in September of 2024 with diagnoses including, but not limited to, hypertension (high blood pressure) and adult failure to thrive. Record review revealed a physician's order dated 9/16/2024 for Hydralazine (a medication prescribed to regulate blood pressure) administer 25 milligrams (mg) three times per day as needed for systolic blood pressure (pressure in your arteries when your heart beats) above 145. Review of the September and October 2024 Medication Administration Records (MAR) revealed that the resident was administered the Hydralazine when the resident's SBP indicated it should be held based on the parameters on the following dates and times: -9/14/2024 133/75 HS (At bedtime) -9/15/2024 112/78 HS -9/18/2024 134/78 Early AM -9/18/2024 132/58 Early PM -9/23/2024 122/76 HS (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9/24/2024 140/54 HS -9/26/2024 128/70 Early PM -9/26/2024 130/46 HS -9/27/2024 142/79 Early AM -9/28/2024 126/60 Early AM -9/28/2024 116/51 HS -9/29/2024 123/59 Early AM -10/2/2024 129/76 HS -10/3/2024 122/68 HS During a surveyor interview on 12/30/2024 at 12:23 PM via the telephone with the facility's Nurse Practitioner, she revealed that she was unaware that the staff were administering the Hydralazine outside of the parameters ordered. Additionally, she revealed that she would expect staff to follow the order as written. During a surveyor interview on 12/30/2024 at 12:51 PM with the Assistant Director Nursing Services, she was unable to provide evidence that the facility staff followed the physician order for Hydralazine. B. Record review revealed a nursing progress note dated 10/21/2024 at 9:47 AM which revealed that the resident's representative called to report that the resident had several loose stools. The note further revealed that this was reported to the Nurse Practitioner. Record review of a nursing progress note dated 10/21/2024 at 1:34 PM revealed that the resident's representative was updated of a new physician's order to test Resident ID #1's stool for C. diff. Record review of a laboratory testing document titled, Microbiology dated 10/22/2024 revealed a positive test result for C. diff. Additionally, there was a new physician's order for Vancomycin 250 mg (an antibiotic) every 6 hours for 10 days and 1 packet of Banatrol (a soluble fiber and a prebiotic which is used to solidify the stool) twice a day. Record review revealed a nursing progress note dated 11/9/2024 at 5:04 PM which revealed that the resident was warm to the touch and lethargic. His/her temperature was 100.4 degrees Fahrenheit. Additionally, Tylenol was administered and a new order was obtained from the physician to start a clysis (an infusion of fluid) and give 1 liter of normal saline. Record review revealed a physician order with a start date of 9/17/2024, for Senna Plus. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October and November 1st through 11th 2024 Medication Administration Records (MAR) revealed that the resident was administered the Senna Plus daily from 9/17/2024 through 11/10/2024, while the resident was experiencing diarrhea and was being treated for C. diff. During a surveyor interview on 12/30/2024 at 12:23 PM with the APRN, she stated, Senna Plus should absolutely not be administered while a resident has C. diff. She further revealed that she was unaware that s/he was receiving this medication and would have expected it to be held and reported to her as a nursing measure to prevent harm to the resident. During a surveyor interview on 12/30/2024 at 12:49 PM with the Assistant Director of Nursing, she confirmed that the Senna Plus was given with an active diagnosis of C. diff and while the resident was experiencing diarrhea.