

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675744	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Friendship Haven Healthcare and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Sunset Dr Friendswood, TX 77546	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26244</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse for 1 of 6 residents (Resident #79) reviewed for abuse.</p> <p>The facility failed to keep Resident #79 free from abuse when RN A yelled at and hit the resident while attempting to give her medication on 10/6/24 at 4:00 AM.</p> <p>The noncompliance was identified as past noncompliance (PNC). The facility corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of experiencing and enduring abuse causing a decreased quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #79's face sheet revealed an original admission on 2/29/24 and Resident #79 was a [AGE] year-old female. Diagnoses included: acute kidney failure (can't filter waste from the blood), hypertension (force of blood against the artery wall was high), COPD (progressive lung disease), Parkinson's (disorder of the central nervous system that affects movement), and epilepsy (a disorder in the brain that caused seizures).</p> <p>Record review of Quarterly MDS assessment dated [DATE] revealed Resident #79's in Section C - Cognitive Pattern her BIMS score was 12 indicating her cognition was moderately impaired. Further review revealed in Section E - Behavior - question B under EO200 for behavioral symptoms, the resident had verbal behavior symptoms directed toward others occurred 1 to 3 days in the 7-day lookback.</p> <p>Record review of current care plan revealed Resident #79 was resistive to care and refused medications at times. Interventions included:</p> <ul style="list-style-type: none"> o Risk for complications r/t refusing care/meds will be minimized and ongoing thru the next review date. o Allow the resident to make decisions about treatment regimen, to provide sense of control. <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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> o Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or o Give clear explanation of all care activities prior to an as they occur during each contact. o Praise the resident when behavior is appropriate. <p>Further record review of current care plan revealed Resident #79 had inappropriate behaviors and was resistive to care. Interventions included:</p> <ul style="list-style-type: none"> o Will comply with care routine/medical regimen and ongoing thru the next review date. o Discuss with resident implications of not complying with therapeutic regimen o If resident refused care, leave resident and return in 5-10 minutes o Maintain consistency in timing of ADL's, caregivers, and routine as much as possible o Monitor behaviors and document number of episodes. o Resident gives self a bed bath daily <p>Record review of incident report for 10/6/24 revealed an altercation between Resident #79 and RN A. It was reported by witness, LVN B, that RN A had threatened and slapped the resident.</p> <p>Observation and interview with Resident #79 on 11/6/24 at 11:28 AM revealed she was in her bed talking to the SW, who came in to talk work with her from another agency. She refused to talk but said she would talk after the SW said it was okay. She said she was not safe, and she was not safe every day. She said she was not afraid though. She was unable to state why she did not feel safe and did not say anything about anyone specific. She said the staff was mean to her every day, but no one had ever hurt her. She would not let them.</p> <p>Interview with the SW on 11/6/24 at 11:25 AM revealed she did psychotherapy with Resident #79 from an agency outside of facility. The resident yelled and constantly said she was not safe . This was her normal behavior, but never related being afraid or what made her unsafe. She stated Resident #79 yelled at the staff but had not mentioned any staff hitting her. She did not see any residual effects from the incident that transpired with RN A.</p> <p>Interview with a police officer on 11/6/24 at 11:04 AM via telephone revealed when he arrived at the facility when he was called for the incident with RN A, the accused staff member was already sent home. He said he and the detective believed it happened , but Resident #79 did not want to press charges .</p> <p>Interview with a detective on 11/6/24 at 12:45 PM revealed the incident did not elevate to assault. He stated there was verbal yelling going on, but there was no injury from being hit. He stated the witness was in the room, and she stated the nurse hit the Resident #79. The resident did not want to press charges.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DON on 11/6/24 at 11:20 AM revealed the incident was witnessed by LVN B. She said RN A was terminated. Resident #79 told the police officer when interviewed she did not want to press charges. She was unable to tell exactly what happened. Resident said she was hit, but she said she was in her wheelchair but the bed. According to the witness she was in her bed.</p> <p>Interview with LVN B on 11/16/24 at 11:45 AM stated she was with Resident #79 in her room on 10/6/24. The LVN B asked the RN A for help give medication to the resident. Resident was refusing her medications. He came into the room and threatened her with giving her a shot, and he hit the resident on the forearm with his open hand. She was surprised that he did that in front of her. She said she never saw him hit anyone else. She went and reported it immediately to the Charge Nurse and they called the DON. She said no one should hit or abuse the residents. The job was about the residents. When asked about trainings, LVN B said they are trained monthly.</p> <p>Interview with the Administrator on 11/6/24 at 11:55 AM revealed RN 1 was terminated for not following ANE policy . They had the witness statement and Resident #79 said she was hit. Resident #79 was assessed and there were no negative effects from the incident. When asked about risk of abuse to the residents, he stated a resident could have mental, physical, or emotional abuse from being hit by a staff member.</p> <p>The facility took the following action to correct the non-compliance on 10/6/24.</p> <p>Record review of the facility investigation revealed the staff was retrained on ANE, witness statement was taken, and assessment was completed. The police, family and physician were contacted. RN A was sent home and suspended immediately.</p> <p>Record review of the facility investigation revealed safe surveys were conducted with residents and no concerns found.</p> <p>Record review of RN A's personnel file found no concerns or any write ups for abuse or neglect. Background checks were current with no concerns. Termination was completed an in the file. RN A was suspended when DON was notified of the incident. He left facility immediately. His termination was on 10/10/24 at the completion of facility investigation.</p> <p>Record Review of Abuse Prevention Program policy, revised December 2016) read in part, .Our residents have the right to be free from abuse .)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>26867</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received meals at regular times comparable to normal mealtimes in the community or in accordance with resident needs and preferences for three of three days (11/04/24, 11/05/24, and 11/06/24) reviewed for frequency of meals.</p> <p>-The facility failed to ensure residents received meals at regularly scheduled times for breakfast and lunch on 11/04/24, breakfast and lunch on 11/05/24, and breakfast on 11/06/24.</p> <p>This failure could place residents who eat from the facility's kitchen, at risk of loss of appetite, weight loss, increased hunger, thirst, frustration, and decreased feelings of self-worth.</p> <p>Findings included:</p> <p>Observation and interview with the Dietary Manager on 11/04/24 at 8:25 AM, revealed the posted mealtime was 7:30 AM for breakfast, 11:30 AM for lunch, and 4:30 PM for dinner. During an interview with the dietary Manager, she said mealtime were 7:30 AM for breakfast, 11:30 AM for Lunch, and 4:30 PM for dinner.</p> <p>Observation and interviews on 11/04/24 at 9:00AM revealed no breakfast trays were served on the 500 and 600 halls. During an interview, with 2 anonymous Residents, the first resident said, his main concerns with the facility were the food. He further explained that the trays are were always late, cold, small sizes and no taste.</p> <p>Observation on 11/04/24 at 10:30 AM, revealed an Anonymous third anonymous resident was sleeping and her Breakfast tray was covered on her bed side table. Observation indicated she did not eat her breakfast.</p> <p>Observation on 11/04/24 at 12:30 PM revealed lunch had not been served on hall 500 and 600 .</p> <p>During an interview with the Dietary Manager at 12:35PM, she said lunch was running late because the dining room was served first, and she was in the process of serving the halls .</p> <p>Observation and interview on 11/04/24 at 12: 50 PM, Anonymous Resident #4 a (third/fourth) anonymous resident appeared s angry. During an interview, she said the meal trays are always late, sometimes cold, the sizes are small like a child's plate, and no test. She said, she did not eat her breakfast because she was served the wrong food. She said she was waiting for lunch, and it had not arrived.</p> <p>Observation and interview on 11/04/24 at 1:00 PM revealed Anonymous Resident #3 was eating her lunch. During an interview she said she did not eat her breakfast because, she was hungry and slept off since she was tired of waiting. She said she had her dinner at about 5:00 PM</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 11/05/24 at 8:50 AM, revealed Anonymous Resident #2 was observed in his room fully dressed. During an interview he said he was waiting for his breakfast. He said he had his dinner at about 5:00PM. He said the only complaint he had was the food. He said the breakfast and lunch trays are always late and sometimes cold.</p> <p>Observation and interview on 11/05/24, revealed breakfast trays were served to the 500 halls at 9:00 AM.</p> <p>During an interview, CNA K said the breakfast always arrived between 8:40 AM and 9:00AM. She said the dining room was served first at about 7:50 to 8:00 AM. She said the CNAs on the halls passed the trays out as soon as they are delivered to the floor because the Residents are always waiting for their breakfast trays in the morning.</p> <p>Observation on 11/05/24 at 12:50 AM, revealed Residents were having lunch in the dining room.</p> <p>Observation on 11/05/24 revealed the lunch trays were delivered to the 500 halls at 1:05 PM and to the 600 halls at 1:08 PM</p> <p>In an interview with the Corporate Manager on 11/05/ 24 at 2:00 PM, she said the appearance of the food on the tray needs more color. She said the trays were late because the fish was hand breaded and fried in the kitchen because the company try to cook all meals from scratch to preserve freshness and nutritive value. She said the trays to the hallways are delivered to the hall on time and but not being distributed immediately. She said she would have an in-service with the Dietary Manager and the staff on the delivery time and she would come up with a plan.</p> <p>During an interview with the Dietary Manager on 11/05/24 at 3:00 PM, she said the trays to the halls are late because the tickets are printed by the Dietary Manager and send back to the unit Manager for verification. She said sometimes the tickets are returned unsorted and the kitchen aide had to sort out the tickets.</p> <p>During the Confidential Resident Council Meeting on 11/05/24 at 2:00PM, 17 anonymous, alert and oriented residents stated that meals were not always on time. All residents said they had to wait up to 1 to 2 hours for a meal be served especially the breakfast.</p> <p>During an interview with the Facility Administrator on 11/05/24 at 4:00 PM, he said the food service department had always been a problem and the facility was actively working on the dietary department to turn things around. He said the facility had changed from one food service company to another and was still working with the present company to ensure that the residents are always served with balance nutritive meals. He said not serving meals on time, may lead to increase hungry and cold food may lead to loss of appetite and possible weight loss.</p> <p>Observation on 11/06/24 revealed breakfast trays was served to 500 halls at 8:26AM and to 600 halls at 8:28 AM. Observation revealed the DON was assisting with the trays on 400 halls.</p> <p>During an interview on 11/06/24 at 9:00 AM LVN D said the meal trays were distributed immediately. LVN D said sometimes the delay comes from the tray arrangement on the cart and the CNA s had to sort through the trays.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 11/6/24 at 9:35 AM, with the Dietary Manager said the meal tickets were not being done well and that had contributed to the late trays. She said the temperatures were not being held on the food carts. She said she did not want to eat cold food and residents would not want too either.</p> <p>During an interview with the Unit Manager on 11/06/24 at 2:00 PM, she said all tickets are printed out by the dietary Manager and all she does, was to verify that the meal orders are correct, and she returns the ticket back to the Dietary Manager the same way that the tickets were handed to her. She said she had no idea how the dietary department handles the tickets during mealtime.</p> <p>A meal service time Facility's policy was requested on 11/06/24 at 10:30 AM. A policy on meal service time was not provided before exit.</p>		