STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675744	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Haven Healthcare and Rehabilitation Cen	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility for 1 of 4 residents (CR #2) reviewed for discharge requirements. The facility failed to ensure CR #2 was readmitted to the facility, after being sent to the hospital for evaluations due to change in condition. This failure could place discharged residents and residents residing in the facility at risk of being discharged and not allowed to return to the facility causing a disruption in their care and/or services.A record review of CR #2's electronic face sheet revealed reflected an [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. CR #2's diagnosis included Dementia, type 2 diabetes mellitus, history of falling, peripheral vascular disease (disorder of the blood vessels), dementia, psychotic disturbance, mood disturbance, and anxiety, essential (primary) hypertension (high bleed pressure) heart disease, anemia (low blood pressure), cerebral infarction (a condition that limit blood flow to the brain), muscle weakness and difficulty in walking,Record review of CR#2's progress note dated 1/23/2025 11:27 revealed eINTERACT SBAR Summary for Providers, Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Seems different than usual. At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 171/68 - 1/23/2025 09:04 Position: Sitting l/arm - Pulse: P 66 - 1/23/2025 09:04 Pulse Type: Regular; - RR: R 18.0 - 1/22/2025 11:57 - Temp: T 96.7 - 1/22/2025 11:57 Route: Forehead (non-contact) - Weight: W 174.5 lbs - 1/2/2025 11:36 Scale: Wheelchair. - Pulse Oximetry: O2 95.0 % - 1/22/2025 11:57 Method: Room Air. - Blood Glucose: BS 242.0 - 1/23/2025 09:32. During an interview with Resident Responsible party on 09/03/25 at 11:30 am, she said the facility had tried several times to discharge CR # 2 from the facility. She said prior to being sent out to the hospital. She had filed an appeal which she won, but the facility still refused to take CR # 2 back after being sent to the hospital. She said CR #2 was discharged to her home without her wheelchair. During an interview with the DON on 09/03/25 at 11:00am, she said CR #2 was sent to the hospital for change in condition. She said the decision not to re- admit CR #2 back to the facility was from corporate office. She said CR #10's RP harassed staff and other residents at the facility. During an interview the Administrator and the facility's Cooperate staff on 09/03/25 at 2:00pm, the Administrator said the decision was from the Cooperation because CR #2 RP harassed, staffs, other residents, and Physician to a point where no staff wanted to work with CR#2. He said he received complaints and resignations letters from staff due to CR#2's RP's behavior. He said he was aware that CR #2 won the appeal, but he had to watch out for the safety of other residents and staff. He said the facility had multiple meetings with CR #2's RP, but the RP continued to harass staff and other resident. He said something was always wrong with how CR #2 was being cared for.Facility's Clinical Director said the facility had gone above and beyond to accommodate CR # 2's RP, and there was nothing the facility could have done differently because the situation was getting worst. An attempt was made on 09/03/25 at 3:00pm to have an interview with CR #2's physician at the time of discharged , but he refused to communicate without his lawyer and would not comment on CR #2 case because it was in court. An attempt was made to contact the hospital social worker but there was no answer. There was no way to leave message. Record review of Facility's policy titled Discharging the Resident dated 2001 and revised 2016 revealed no evidence of discharge after an appeal process.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to incorporate recommendations from a PASRR evaluation report into a resident assessment, care planning, and transition of care for 1 (Resident #1) of 3 residents reviewed for PASRR services.The facility failed to submit Resident #1's NFSS in the LTC online portal within 20 days after the IDT meeting. This failure could place residents who were PASRR positive at risk of not getting the PASRR services for a better quality of life and could lead to a decline in health. Record review of Resident #1's face sheet dated 09/03/25 revealed a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included- Profound intellectual disabilities, major depressive disorder, anxiety disorder, bilateral primary osteoarthritis of knee, (tissue wears down) prediabetes, gastric ulcer, anemia (Low Blood count), age-related osteoporosis, and end stage renal diseaseRecord review of Resident #1's PASRR evaluation dated 12/27/25 indicated Resident #1 was positive for Intellectual disability.Record review of PCSP dated 01/29/25 indicated there was a recommendation for Resident #1 to receive a customized manual wheelchair.Record review of Resident #1's clinical records revealed no evidence of the NFSS form. During an interview on 09/03/25 at 1:00PM, the Administrator said MDS Coordinator A was responsible for doing PASRR. She provided During an interview with MDS Coordinator A on 09/03/25 at 1:30PM, she said Resident #1's NFSS was not submitted because at the time of the meeting and recommendation, Resident #1 had no payer source and was not aware that she could submit the NFSS without being approved for Medicaid. She said failure to submit the NFSS, as required, may prevent residents from receiving services needed for their wellbeing. Policy on PASRR submission was requested on 09/04/25 from MDS Coordinator but not provided prior to exit on 09/04/25