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	02/20/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) of enteral feeding for 1 (Resident #56) of 8 residents reviewed for enteral nutrition.The facility failed to ensure LVN A used the appropriate procedure for checking placement and administering flushes and medication during medication administration. The facility failed to ensure LVN A did not use air to check for placement. The facility failed to ensure LVN A used the appropriate amount of water to dilute medication and to flush in between medication administration.These failures could have placed residents with a gastrostomy tube at risk for complications, aspiration, and pneumonia.Findings included:Record review of Resident #56's face sheet dated 01/19/2026 revealed an [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included: cerebral infarction (a type of stroke caused by blockage of blood vessel leading to cell death due to lack of oxygen), dysphagia following cerebral infarction (difficulty swallowing after a stroke), gastrostomy status (a tube is surgically inserted into the stomach), and hypertension (condition where the force of blood pressure against the artery wall is consistently too high).Record review of Resident #56's admission MDS assessment dated [DATE], revealed under section C1000 the resident was severely impaired in condition. The MDS indicated the resident was dependent on staff for all ADL care and G-tube care.Record review of Resident #56's clinical physician's order for February 2026, indicated .check GTube placement prior to . medication administration by aspiration of gastric content. Flush GT with 30ml water pre/post medication administration and flush 10 ml water between med every shift . Amlodipine 5mg give 1 tab via gtube two times a day, Coreg Oral Tablet 6.25 MG (Carvedilol) give 1 tablet via G-Tube two times a day, Lansoprazole 30mg give 1 tablet via G-Tube two times a day, Docusate Sodium give 1 tablet via G-Tube one time a day, Aspirin 81 give 1 tablet via G-Tube one time a day, Lactobacillus give 1 capsule via PEG-Tube one time a day.Record review of Resident #56's medication administration record for February 2026, read in part .check GTube placement prior to . medication administration by aspiration of gastric content. Flush GT with 30ml water pre/post medication administration and flush 10 ml water between med every shift. Amlodipine 5mg give 1 tab via gtube two times a day, Coreg Oral Tablet 6.25 MG (Carvedilol) give 1 tablet via G-Tube two times a day, Lansoprazole 30mg give 1 tablet via G-Tube two times a day, Docusate Sodium give 1 tablet via G-Tube one time a day, Aspirin 81 give 1 tablet via G-Tube one time a day, Lactobacillus give 1 capsule via PEG-Tube one time a day.During an observation and interview on 02/18/26 at 8:45 a.m., during medication administration for Resident #56, LVN A drew up 30 cc of air in the syringe, opened the resident's G-tube, and pushed the air into the G-tube. LVN A stated she used the 30 cc of air to check for placement. ADON B gave LVN A each medication cup which had the crushed medication that was not dissolved. LVN A told ADON B to use one of the cups which had 10 ml of water and pour some of the water into the medication cup which she had in her hand. LVN A then swirled the medication cup several times and administered the medications through the G-tube, and she poured the remaining water from the 10 ml cup into the G-tube for flush in between each (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication. LVN A and ADON B repeated the process for all the medications.During an interview on 02/18/2026 at 9:02 a.m., ADON B said LVN A should have followed the physician order or facility policy for Resident #56 regarding how many ml of water was needed for dissolving crushed medication during medication administration via G-tube. ADON B stated she would review the G-tube policy for placement check and amount of water needed to dissolve the crushed medication for G-tube medication administration.During an interview on 02/18/26 at 9:10 a.m., LVN A said she did not use the required amount of water according to facility policy or physician order for dissolving the medication and flushing in between medication for Resident #56. LVN A said medication could clog up the G-tube if the medication was not dissolved completely or G-tube was not flushed with adequate amount of water. LVN A stated she thought she could use air to check for placement because the skills check-off training said you could use air. She said she did not know the order said to aspirate to check for placement. She did not respond when she was asked what could have happened to Resident #56 if air was pushed into the G-tube.During an interview on 02/19/26 at 8:50 a.m., the DON said LVN A should have aspirated the stomach content instead of pushing air into Resident #56's G-tube. She said the air could have caused false confirmation or pneumonia for the resident. She said LVN A should have used the amount of water to flush as ordered by the physician or the facility policy. She said if LVN A did not use the appropriate water flushes during medication administration, the medication could have clogged the G-tube.Record review of the facility policy on administering medication through an enteral feeding tube dated 2001 MED-PASS, Inc., Revised March 2015, read in part. The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . Steps in Procedure. #18 Confirm placement of feeding tube per physician's order by aspirating stomach contents; if no residual is aspirated check for bowel sounds, bloating, vomiting and pain. If no changes are noted proceed to administer medications. #23 Dilute the crushed or split medication with 10-30 mL. #26 If administering more than one medication, flush with 10-15 mL (or prescribed amount) room temperature tap water between medications. #27 When the last of the medication begins to drain from the tubing, flush the tubing with 10-15 mL of warm room temperature tap water .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 12%, based on 3 errors out of 25 opportunities, which involved 1 (Resident #56) of 5 residents reviewed for medication errors.The facility failed to ensure/ prevent when LVN A left a substantial amount of medication residue for Amlodipine 5mg give 1 tab via G-tube two times a day, Coreg Oral Tablet 6.25 MG (Carvedilol) give 1 tablet via G-Tube two times a day, and Lansoprazole 30mg give 1 tablet via G-Tube two times a day in the medication cups after medications were administered through a g-tube to Resident #56. These failures could have placed residents at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health.Findings included:Record review of Resident #56's face sheet dated 01/19/2026, revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: cerebral infarction (a type of stroke caused by blockage of blood vessel leading to cell death due to lack of oxygen), dysphagia following cerebral infarction (difficulty swallowing after a stroke), gastrostomy status (a tube is surgically inserted into the stomach), and hypertension (condition where the force of blood pressure against the artery wall is consistently too high).Record review of Resident #56's admission MDS assessment dated [DATE], revealed under section C1000 the resident was severely impaired in condition. The MDS revealed the resident was dependent on staff for all ADL care and G-tube care.Record review of Resident #56's clinical physician's order for February 2026, indicated . check GTube placement prior to . medication administration by aspiration of gastric content. Flush GT with 30ml water pre/post medication administration and flush 10 ml water between med every shift . Amlodipine 5mg give 1 tab via G-tube two times a day, Coreg Oral Tablet 6.25 MG (Carvedilol) give 1 tablet via G-Tube two times a day, Lansoprazole 30mg give 1 tablet via G-Tube two times a day, Docusate Sodium give 1 tablet via G-Tube one time a day, Aspirin 81 give 1 tablet via G-Tube one time a day, Lactobacillus give 1 capsule via G-Tube one time a day.Record review of Resident #56's medication administration record for February 2026, indicated .check GTube placement prior to . medication administration by aspiration of gastric content. Flush GT with 30ml water pre/post medication administration and flush 10 ml water between med every shift. Amlodipine 5mg give 1 tab via gtube two times a day, Coreg Oral Tablet 6.25 MG (Carvedilol) give 1 tablet via G-Tube two times a day, Lansoprazole 30mg give 1 tablet via G-Tube two times a day, Docusate Sodium give 1 tablet via G-Tube one time a day, Aspirin 81 give 1 tablet via G-Tube one time a day, Lactobacillus give 1 capsule via PEG-Tube one time a day.During an observation on 02/18/26 at 8:45 a.m., medication administration for Resident #56 was conducted by LVN A and assisted by ADON B. The following medications were administered: Amlodipine 5mg 1 tab bid, Carvedilol 6.25 mg 1 tab bid, Lansoprazole 30 mg 1 tab, stool softener 100mg give 1 tab, chewable aspirin 81 mg 1 tab, and acidophilus 75 million 1 tab. When LVN A finished administering the medications, there was a substantial amount of medication remaining in 3 portion cups. LVN A did not administer 3 (Carvedilol 6.25 mg 1 tab bid, Amlodipine 5mg 1 tab bid, Lansoprazole 30 mg 1 tab, out of the six medications because there was a substantial amount of the medications left in the portion cups. The medications were not completely dissolved and there were significate medication residual left in the three medication cups.During an observation and interview on 02/18/26 at 9:00 a.m., ADON B said there was a substantial amount of medication residue left in the 3 medication cups and LVN A should have stirred the medication with a spoon before administration. She said Resident #56 did not receive the medications as ordered.During an interview on 02/18/26 at 9:09 a.m., LVN A said she should have dissolved the medication for Resident #56 with the recommended amount of water and stirred the medication before she administered the medication, which would have prevented a significant amount of medication residue being left in the medication cups. LVN A said Resident #56 did not get all the medications as prescribed by the physician. She said the medication would not been effective for the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment it was prescribed because the medication cups had substantial amount of medication left in the cups.During an interview on 02/19/26 at 8:57 a.m., the DON said Resident #56 did not get the prescribed dose of medication because there was a lot of medication residue left in the medication cup. She said medications would not be effective if the correct dose was not given for the diagnoses it was prescribed because the medication cups had substantial amount of medication left in the cups.Record review of facility policy on Administering Medication 2001 MED-PASS, Inc. Revised December 2012 read in part . Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation #3 Medications must be administered in accordance with the orders.